DEFERRAL OF HEALTH BENEFITS FORM FOR LTNP GGU DIVISION OF FORESTRY

Wildland Fire and Resource Technicians, Natural Resource Technicians, and Foresters

ASEA Health Benefits Trust

Address: PO Box 5434, Spokane, WA 99205 • Phone: 866-553-8206 (toll-free); 509-328-0300
Fax: 509-323-7614 • Website: www.aseahealth.org

Use this form only if you choose to defer your health coverage benefits. By submitting this form, signed by your supervisor, you will be delaying the effective date of your health benefits by one or two months past the date your coverage would have otherwise started, and the termination of your health benefits will be deferred by one or two months, past the date your coverage would have otherwise terminated.

As a newly hired long term, non-permanent employee, your health benefits will take effect on the first day of the month following 30 consecutive days you are in paid status, provided contributions have been submitted by your Employer. Once you have established eligibility, your coverage remains in effect through the last day of the month in which you were in paid status.

NOTICE:

ONCE YOU SUBMIT THIS DEFERRAL FORM, IT CANNOT BE REVOKED FOR ANY REASON, OR UNDER ANY CIRCUMSTANCE. DEFERRAL OF YOUR HEALTH BENEFITS WILL ALSO DEFER HEALTH BENEFITS FOR ALL ENROLLED DEPENDENTS. DURING THE DEFERRAL PERIOD, YOU AND ANY ENROLLED DEPENDENTS WILL NOT HAVE HEALTH BENEFITS COVERAGE.

Deferral Examples	No Deferral	One Month Deferral	Two Month Deferral
Hire Date	May 1	May 1	May 1
First Day of Coverage	June 1	July 1	August 1
Last Day of Employment	September 30	September 30	September 30
Last Day of Coverage	September 30	October 31	November 30

PLEASE PRINT CLEARLY

Employee name: Alternate ID No.:

Employee address:

City/State/Zip:

Employee phone: Employee email:

Names of dependents, if any, who will also be deferred:

I choose to defer the effective date of my health benefits for: ❑ One Month **OR** ❑ Two Months

By signing below I understand that:

- I am electing to have the effective date of my health benefits and my dependents' health benefits if applicable, deferred for the period of time marked above;
- this deferral will have no effect on any option I have chosen for HCRA/HRA;
- I must submit a new Deferral Form each time I return to work if I wish to have my future benefits deferred;
- this Deferral cannot be revoked once submitted.

You must have this form signed by your supervisor to be eligible for any deferral.

Supervisor name: Supervisor signature:

Employee signature: Date:

The DEFERRAL OF HEALTH BENEFITS FORM must be postmarked or faxed to the ASEA/AFSCME Local 52 Health Benefits Trust within 30 days of the date you start employment. You must also give a copy to your Departmental Personnel Office. It is your responsibility to make sure this form is received by the Health Trust Administrator.