



HARRISON TRUST

A Family Health Plan

www.harrison.aibpa.com

RETIRED PLANS A, B, C BENEFIT APPLICATION

I request to be added to the Retired Benefit Group. I understand my reserve hours will be used until exhausted to offset any payments I must make. I apply for retirement health benefits effective:_____

EMPLOYEE DATA:

Name in Full _____

Date of Birth _____

Social Security Number _____

Local Union Number _____

Spouse - Name in Full _____

Spouse - Date of Birth _____

Spouse - Social Security Number _____

Permanent Address _____

I make this application with the understanding that I am not engaged in the Electrical Industry at this time for wage or profit and shall forfeit all benefits, should I, without prior Trustee approval, become engaged in the Electrical Industry for wage or profit.

I understand that it is necessary to enroll in parts A and B of Medicare at age 65 or when eligible to participate in the Retired Plan.

Applicant's Signature

Date

This application must be sent to the Administrator's office for processing:

Harrison Trust
1220 SW Morrison, Ste 300, Portland, Oregon 97205)

ADMINISTRATOR'S REPORT:

- 1. Number of Months Covered:_____
- 2. Disability Effective: _____
- 2. Five Years in Trade After Age 50? _____
- 4. Medicare Effective: _____

Administered by A&I Benefit Plan Administrators, Inc.
1220 SW Morrison St., Suite 300, Portland, OR 97205-2222
(503) 224-0048 ext. 1679 (800) 547-4457 ext. 1679 Fax (503) 228-0149