Election of Medical Reimbursement Program (MRP) as a Stand-Alone Option

I wish to enroll in Plan C-Medical Reimbursement Program (MRP) as a stand-alone option, as described in the Summary Plan Description, pages 26-35. (The Summary Plan Description is available upon request from the Fund Office and on the website, www.iatsenbf.org).

To be eligible for the Plan C-Medical Reimbursement Program (MRP) as a stand-alone option, I understand that I and any dependents I enroll, must have medical coverage with another employer or union sponsored group health plan that provides minimum value under the Patient Protection and Affordable Care Act (ACA). To enroll in this option and waive enrollment in C1, C2, C3, C4 or Triple S (if you reside in Puerto Rico), I acknowledge that I must sign this election form and submit proof of other employer or union sponsored group health coverage (**copy of front and back of coverage ID card along with a statement from insurer or plan sponsor if my ID card does not specify that it is group coverage**). By signing this form, I hereby certify that my and my enrolled dependents (if any) other coverage is through an employer or union sponsored group health plan that provides minimum value coverage under the ACA. In addition, recertification and proof of other employer or union sponsored group health coverage must be submitted annually during the Plan's Open Enrollment period. I also agree to inform the Fund immediately, in writing, if I or my dependents lose such other coverage.

Note, if you are enrolled in the Medical Reimbursement Program (MRP), a $60 quarterly administrative fee will be deducted from your CAPP account.

Participant Name: ______________________________

Participant ID: ______________________________

Name on Policy: ______________________________

Name of Employer or Union providing coverage: ______________________

Name of Primary Insurance Company: __________________________

Your signature below and copy of the front and back of your ID card are required for enrollment in MRP.

Signature _____________________ Date: ______________

You can email this form to psc@iatsenbf.org or fax it to 646-783-7650.