

Graphic Communications National Health and Welfare Fund

Benefit Plan Proposal Request

Please indicate below, which lines of coverage you wish to have a rate quoted from the National Fund:

Medical	£	Prescription	£
Dental	£	Vision	£
Medicare Supplement	£	Short Term Disability	£
Life and AD&D	£		

Please answer this short survey in order for us to assist you in selecting the appropriate benefits offered by the National Health and Welfare Fund:

1. Please indicate the types of benefits, and the name of the carrier that your participants currently have their benefits through:

Coverage	Carrier	# of years with Carrier
£ HMO		
£ PPO		
£ POS		
£ Prescription		
£ Dental		
£ Vision		
£ Medicare Supplement		
£ Short Term Disability		
£ Long Term Disability		
£ Life and AD&D		
£ Other: _____		

2. Are you operating under a Trust Fund arrangement? Yes £ No £

3. What is the next date of renewal with your current carrier? _____

4. What is the expiration date of your current plans? _____

Print Name/ Title

Signature

Date

Local Union#

Employer

E-Mail Address