UA Local 190 Health and Welfare Plan
IHRA PRE Authorization

Member Name: _____

Last Four Digits of SSN: XXX-XX-_____

I understand that in order to continue eligibility under the UA Local 190 Health and Welfare Plan I must work 100 hours per month. I further understand that I will not have any coverage for medical expenses incurred after the month that follows the month in which I have less than 100 hours of covered employment unless I make a self-payment.

The Plan offers two different self payment options to prevent loss of coverage due to the 100 hour rule as follows:

A. The first option provides for "lower payments" (as compared to the full COBRA rate) in the 12 month period (available within any 18 month period) following loss of coverage. These lower payments are only available for Members who are available for work (i.e. on the "on the out of work" list), who make the self –payments on time as required by the Plan and are in good standing with the Union.

B. The second option is "COBRA " with much higher premiums. This option is the "last chance" for those who don't qualify for the lower self payments, fail to make timely self payments, exhaust the 12 month lower payment period or lose coverage due to another COBRA qualifying event.

☐ I authorize the UA Local 190 Health and Welfare Plan to automatically withdraw monies from my IHRA Fund account to pay my monthly self—pay if I have not made a payment made by the last day of the month in which the self-payment is due.

☐ I understand that I may revoke this authorization at any time, by giving written notice to:

UA Local 190 Health and Welfare Plan
30700 Telegraph RD. Ste. 2400
Bingham Farms, MI 48025

Member Signature: _____ Date: _____

Witness Signature: _____ Date: _____