International Union of Painters and Allied Trades

(IUPAT)

↓

District Council #4

↓

Glaziers Local #677

District Council #4

Michael Hogan

Business Manager Secretary Treasure

Departments

Servicing	Organizing	Office Staff	Training	Trust Funds
Director	**Director**	**Fin. Secretary**	**Director**	**Manager**
Brian Lipczynski #660	Frank Stento	Heather Velie	Marc Braunstein	Sue Bernat
Business Reps	**Organizers**	**Admin**	**Coordinators**	**Benefits Admins**
Joe Comfort #677	Guy Falsetti	Judy Salansky	Bob Brueckman (WNY)	Velitchka Kireva
David Chaffee #150	Wesley Schlossin	**Dues Admin**	Josh Osterhout (CNY)	Wendy Styn
Dominic Zirilli #43/#112	Don Meyers	Shannon Albano	**Staff**	Victoria Antonicelli
Dan LaFrance #31/#38	Joe Guza		Kathy Velie	Nancy Haddad
Dan Jackson #11/#178			Hillary Laud	

District Council #4/Glaziers Local #677
Information/Numbers

www.dc4.org

District Council #4 Headquarters:
585 Aero Drive
Cheektowaga, Ny 14225
Phone# (716) 565-0303

CNY Training Center
1875 Lorings Crossing
Cortlandville, Ny 13045

Business Manager: Michael Hogan
585 Aero Drive
Cheektowaga, NY 14225
mhogan@dc4.org

Dues: Shannon Albano
585 Aero Drive
Cheektowaga, NY 14225
Phone# (716) 565-0303
salbano@dc4.org

Funds Office: Wendy Styn
585 Aero Drive
Cheektowaga, NY 14225
Phone# (716) 565-0234
wstyn@dc4.org

Business Representative DC #4/ Local 677: Joe Comfort
6605 Pittsford Palmyra Rd E-6
Fairport, NY 14450
Phone# (585) 727-6228
jcomfort@dc4.org

Director of Organizing: Frank Stento
168 Susquehanna St
Binghamton, NY 13904
Phone# (607) 727-5208
fstento@dc4.org

District Council #4/Local #677
Information/Numbers

www.dc4.org

Apprentice Department
585 Aero Drive
Cheektowaga, NY 14225
Phone# (716) 565-0112

Director of Training and Apprenticeship: Marc Braunstein
mbraunstine@dc4.org

Apprentice Coordinators:
Josh Osterhout (CNY)
Phone# (607) 429-9401
josterhout@dc4.org
Bob Brueckman (WNY)
Phone# (585) 815-5112
rbrueckman@dc4.org

Apprentice Department Staff:
Kathy Velie
Kvelie@dc4.org
Hillary Laud
hsansone@dc4.org

International Pension Office
7234 Parkway Drive
Hanover, MD 21076
Phone# 1-800-554-2479

Glaziers Local 677

www.dc4.org

Union Meetings are the first Monday of the Month @ 5pm

Rochester- In person 6605 Pittsford Palmyra Rd E-6 Fairport, NY 14450

Syracuse- Zoom link will be sent in a text message

Binghamton- Zoom link will be sent in a text message

Glazier Collective Bargaining Agreement
CBA

Glaziers Local 677

Social Media Information

Glaziers 677 Private Group

Glaziers 677 Instagram

GLAZIERS_LOCAL_677

Glaziers 677 Facebook page

TOOLS REQUIRED FOR THE GLAZING TRADE

The Glazing trade requires various tools, here is a list of tools you will need to perform your work. You will need to acquire more tools accordingly, but this is a good starting point in order of tools needed.

- Tool Bag
- Tape Measure (25’ is recommended)
- Utility Knife
- Tin Snips
- Mallett/Dead Blow
- Pry Bar (Jimmy Bar)
- Pruning Shears with Anvil
- Combination Square
- Speed Square
- Caulk Gun
- Caulking Tools
- Razor Scraper Handle
- Large Pry Bar (18” or 24”)
- Allen Wrench Sets (Standard & Metric)
- Vice Grips (Regular & Needle Nose)
- Torpedo Level
- Files
- Screwdriver Set
- Hack Saw
- Tool Belt

Glaziers Local #677

Rochester/Syracuse/Binghamton

International Union of Painters & Allied Trades, District Council #4

Business Representative: Joe Comfort 585-727-6228

6605 Pittsford Palmyra Rd. Suite #E6, Town of Perinton (Fairport), NY 14450
(585) 271-2490 Fax (585) 271-2907
jcomfort@dc4.org

Ajay Glass & Mirror Co. Inc. 101 North Street Canandaigua, New York 14424 Phone: 585-393-0082 Fax: 585-393-0105 Contact: Jim Stathopoulos, President Email: jims@ajayglass.com or steves@ajayglass.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private	**Utica Glass Company** P.O. Box 528 Utica, New York 13503 Phone: (315) 732-5131 Fax: 315-732-2437 Contact: Gary Puleo Email: garypuleo@uticaglass.com or gp2@uticaglass.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private/Res.
Binghamton Plate Glass 430 State Street Binghamton, New York 13902 Phone: 607-723-8293 Fax: 607-723-5561 Contact: Diane Emmi Email: bingplateglass@stny.rr.com dianebpg@stny.rr.com Curtain Wall/Light Commercial/ Public/Private	**N.E.P. Glass Co. Inc.** P.O. Box 277 6224 State Route 5 Little Falls, New York 13365 Phone: 315-823-8800 Fax: 315-823-2330 Contact: Jim Smith Email: jsmith@nepglass.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private & Residential
BRG (Buffalo Road Glass) 111 Buffalo Road Rochester, New York 14611 Phone: 585-235-8560 Fax: 585-235-5322 Contact: Gus Tamoutselis or Mike Bassett Email: gus@brgcorporation.com or mbassett@brgcorporation.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private	**Forno Enterprises, Inc.** County Rd. #27 Trout Creek, New York 13847 Phone: 607-865-7860 Fax: 607-865-4392 Contact: Brian Albanese, President Email: brian@teamforno.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private
Sterling Glass & Dual Pane 1415 Niagara St. Buffalo, New York 14213 Phone: 716-853-5800 Fax: 716-853-5805 Contact: Marty Loughran Email: mloughran@sterlingglassinc.com Curtain Wall/ Storefront/ Pre-Glazed Public/Private	**Southern Glass Service** 3131 State Route 352 Big Flats, New York 14814 Phone: 607-562-3029 Fax: 607-562-3104 Contact: Rebecca Roe/Chris Dean/Jim Sherwood Email:rroe@southernglassservice.com cdean@southernglassservice.com Curtain Wall/Storefront/Pre-Glazed/Panels Public/Private

To New Member:

On_____2024 you made an application with DC#4/Local#677. You agree in part to pay a $100.00 Initiation fee which will be due in 45 days. We have multiple ways for you to pay this fee.

1. You can mail a check to DC#4 Headquarters 585 Aero Dr. Cheektowaga, NY 14225 & attention it to Shannon Albano.

2. You can call (716) 565-0303 and make a payment with Debit/Credit Card. Your contact here again will be Shannon Albano

3. You can also make a payment to the Business Representative of the Local you belong to & will be given a receipt at the time of payment.

Thank you for your timely response to this matter.

Thank you,

Joe Comfort

Regional Business Representative DC#4/Local#677

D.C. #4's 16th Annual STAR Safety Awards

Date, Time & Place to be announced

STAR Raffle Requirements:

1. Must be a Member in good standing at the time of the Awards Ceremony.
2. Must be present at the 2023 Awards Ceremony.
3. Must complete a minimum of 800 "work hours" of employment for a signatory/signed employer during the Qualifying Period.
4. Must complete the Training Course requirements by the end of the Qualifying Period.

2023 STAR Course Requirements:

For each 16 hours of classroom//hands-on training you receive during the Qualifying Period in a **Qualifying Class** at the Finishing Trades Institute of Western & Central New York, (the "Training Fund"), you will be entitled to one chance in each prize category. You must complete and pass the course to receive credit towards the 16 hours. To receive a list of classes or enroll in a class, you should call (716) 565-0112 Monday through Friday, 8:00 a.m. to 4:30 p.m.

As an example: If you complete and pass a 32 hour classroom/hands-on training class, you will have (02) chances for the Grand Prize Raffle & (02) chances for the Primary Prize Raffle and (02) chances for the Secondary Prize Raffle so in other words, every 16 hours of classroom /hands-on training puts your name in for another chance for each Prize Category.

:::::: Important Definitions ::::::

Members in Good Standing: An apprentice or journey worker whose dues are currently paid and up to date. Members in good standing who are excluded from the raffle are: Business Manager, Regional Business Representatives/Organizers and staff of the District Council. Training Fund instructors are eligible if they meet the Safe Hour requirement through work under the collective bargaining agreement with a signatory employer, and complete the required courses as a student.

Qualifying Class: Any health, safety or training class offered by or approved of by the Training Fund, completed and passed by you during the Qualifying Period. As stated, you must complete the class to receive credit towards the 16 hour requirement. You cannot duplicate any Health & Safety classes in the Qualifying Period.

Qualifying Period: ***May 1, 2022 to April 30, 2023***

Attending Local Union Meetings: For every Local Union meeting attended during the qualifying period, you will receive one (1) STAR credit hour.

Stipulation: You must attend and complete at least one (1) Health & Safety or Journeyman Upgrading class.

	PAINTERS DISTRICT COUNCIL #4 HEALTH & WELFARE FUND OPEN ENROLLMENT EFFECTIVE MARCH 1, 2023: BENEFIT SUMMARIES		
	PROPOSED BENEFIT OPTION 800 (HIGH)	PROPOSED BENEFIT OPTION 800 (MED)	PROPOSED BENEFIT OPTION 800 (LOW)
IN-NETWORK DEDUCTIBLE CO-INSURANCE OUT OF POCKET MAXIMUM	$500/$1,000 90%/10% $2,500/$5,000	$2,000/$4,000 80%/20% $4,000/$8,000	$2,000/$4,000 80%/20% $5,000/$10,000
OUT-OF-NETWORK DEDUCTIBLE CO-INSURANCE OUT-OF-POCKET MAXIMUM	$1,500/$3,000 70%/30% $5,000/$10,000	$3,000/$6,000 60%/40% $6,000/$12,000	$3,000/$6,000 60%/40% $10,000/$20,000
PHYSICIAN COPAY SPECIALIST COPAY	$20 $30	$25 $40	20% AFTER DEDUCTIBLE 20% AFTER DEDUCTIBLE
HOSPITAL COPAY	$500	20% AFTER DEDUCTIBLE	20% AFTER DEDUCTIBLE
OUTPATIENT SURGERY COPAY EMERGENCY ROOM URGENT CARE	$75 $150 $50	20% AFTER DEDUCTIBLE $150 $50	20% AFTER DEDUCTIBLE 20% AFTER DEDUCTIBLE 20% AFTER DEDUCTIBLE
PRESCRIPTION DRUG	$5/$30/$50 AT RETAIL (2.5 TIMES AT MAIL)	$5/20%/20% AT RETAIL ($150 MAX/$250 MAX) (2.5 TIMES AT MAIL)	$15/50%/50% AT RETAIL (AFTER DEDUCTIBLE) (2.5 TIMES AT MAIL)
SINGLE RATE TWO PERSON RATE FAMILY RATE	$718.48 $1,436.95 $1,975.82	$579.25 $1,158.49 $1,592.93	$456.19 $912.36 $1,254.50

District Council # 4 Trust Funds Rochester/CNY/Elmira Quick Reference Guide

Contributions being Entered: Contractors have 45 days "after a month end" to send in a remittance report for work performed. When contractors send in monthly reports, it may not reflect the most current work performed, (ie: remittances for work performed for the month of May does not have to be submitted until July 15th).

Effective dates of Contributions: Once the Trust Funds receives a contribution, the member contributions will be based on the following:

HCA/WRA Splits: Basis on how splits are computed:

****A single contribution cannot be split multiple ways regardless of the dollar amount in your HCA/WRA. (This may put your HCA/WRA over the $1,500/$12,500 limit for that single contribution—the next contribution will be split accordingly)**

1. **HCA**-All HCA accounts must be at a minimum of $1,500. Contributions will go 97% into HCA until that amount is met. (3% is admin fee out of the WRA)
2. **WRA**- If WRA reaches $12,500, contributions will revert back to 97% into HCA (3% admin fee out of the WRA)
3. Health insurance type/level of coverage and split:

Single	50/50
2 Person	80/20
Family	97/3
HCA Amt below $1500	97/3
No longer receiving Health Ins	80/20
Waive/ Employer based	20/80
Waive/Non Employer based	20/80

4. Date order of contribution: **A contribution will be allocated as of the Payroll ending date of the contribution.** Therefore whatever the health insurance status is at the payroll ending date of the contribution, will have the split go according to the split table above (in some instances- if contributions are sent in after a more current remittance from a contractor, the date order cannot be followed).

Unemployment PAP Benefits $250: Member must have money in **WRA**, must show proof of unemployment history and complete request form.

Unemployment Waiting Week ($400): Member must have money in **WRA**, must show proof of unemployment history and complete request form.

Medical Reimbursements: This is a reimbursement program, therefore you must pay the bill before submitting for reimbursement. A Claim form along with the patients' name, statement of charges, service provided and date must be submitted with proof of payment, or claim may be denied.

****In order to get reimbursed for out of pocket medical, dental and vision expenses, you must have employer based insurance either through DC#4 or your spouse's employer. If you have your spouse's coverage, a waiver form must be on file showing the dependents who have the employer sponsored coverage. If any dependents are not on employer based coverage, no reimbursements can be made on their behalf.**

Health/Dental Insurance: Members must have the minimum balance of $1,500 in the HCA in order to qualify for coverage. Paperwork will be sent in the mail. Members have 30 days from a qualifying event to enroll or members must wait until the annual Open Enrollment. Call the Trust Funds Office for rates.

Direct Deposit: We offer direct deposit for pap checks (vacations/holidays/medical reimbursements/pap benefits). We need to have the form completed along with a voided check or a statement from the bank with your routing and account number. Direct deposits go in the bank on Thursdays.

** If you owe documentation or need to sign for your check, we cannot release the funds, therefore you will have a paper check that week.

Inactivity Bucket:

If there is no contribution to, or distribution from your Health Care Account or Wage Replacement Account for a period of sixty (60) consecutive months, then any balance in those accounts will be forfeited and added to the Fund's reserves. Further, any balance remaining in your Health Care Account upon your death (if you are not survived by a spouse or eligible dependents), or upon the death of the survivor of your spouse or eligible dependents, will be forfeited and added to the Fund's reserves. Any balance remaining in your Wage Replacement Account will be forfeited upon your death and added to the Fund's reserves.

Vacations:

There is a maximum of six (6) weeks of vacation that can be taken between June 1st and May 31st of the following year. FICA and Medicare taxes are mandatory to be taken as well as personal withholdings for state and federal taxes. Vacations are taken with the status of Apprentice ($850.00 comes out of WRA), Industrial ($850.00 comes out of WRA), or Journeyman ($1,600.00 comes out of WRA). If a member calls in the request, they will need to pick up the check on Thursday or Friday and sign for it. If you owe documentation or need to sign for your check, we cannot release the funds, therefore you will have a paper check that week.

Holidays:

There are nine (9) holidays that can be taken each year. The cut off for taking the prior year's holidays is May 31st. You cannot request a holiday that is more than one week in the future (ie: Christmas Day cannot be requested until **one week prior** to that holiday occurring on the physical Calendar).

HIPAA Forms:

HIPAA forms allow members' spouse, parent or whomever they chose to be able to call/come in to discuss the options below: **PLEASE** complete one as spouses and parents may not understand when we are unable to give them account balances or info on when contributions came in and how much was contributed.

Specific description of information to be used or disclosed: (Please check all that apply)

☐ Health Care Acct Balances ☐ Medical Bills/Receipts ☐ Reimbursement Checks

Specific purpose of the disclosure:

☐ Submission of Medical Claims ☐ Balance, status Inquiries ☐ Allowed to pick up reimbursement checks

Bereavement:

- Up to three (3) days at $300 per day for days missed from the job (you cannot be collecting unemployment)
- You must also have worked the business day before the bereavement days requested for, as well as the day after the last bereavement day requested.
- Funds must be available in the WRA in order to receive this benefit (if the funds are not available at the time of bereavement, this is valid one year from the date of passing).
- Bereavement request from and proof of death (obituary or death certificate) of family member is required.

- This only applies for immediate family members (parent or parent-in law, grand parent, spouse, child or sibling).
- Applicable to Social Security and Medicare employer and employee taxes in addition to federal and state taxes.

Disability/Workers Compensation Benefit:

- Proof of collection of benefits (a copy of the check stub) is mandatory in order to be eligible for such benefits
- These checks are subject to Social Security and Medicare taxes (both employer and employee portions)
- Personal Federal and State taxes are optional to the member
- Funds must be available in your WRA in order to collect these benefits
  ie: for two (2) weeks of disability- a total of $500.00 ($250 each week), you are required to have a balance of $562.75 in your WRA to receive the benefit.

Life Insurance: Members who work 500 hours between May 1st and April 30th of the next year will qualify for our Hartford Life insurance benefit (free of cost). The plan year runs from August 1st to July 31st the following year.

The benefit breakdown is as follows:

- $50,000 coverage for the member
- $5, 000 coverage for the members spouse
- $2,500 coverage for the members eligible dependents ages 6 months to 19 years of age
- $250 coverage for the members eligible dependents ages 14 days to 6 months

Note: A beneficiary designation form is mailed out to all of the members upon qualification that needs to be completed and returned to DC#4 EVERY YEAR. It is ***your responsibility* to make sure the beneficiary form is completed and turned in at a timely manner to ensure you or your beneficiaries will receive these benefits.

Address:

Always keep your address updated with District Council #4. This is very important for mailings, W-2's and checks getting mailed out.

The Address change form is located on our DC4 website or you can obtain the form by calling the District Council #4 Office at 716-565-0303. Address change forms must be notarized and sent back to DC#4.

IUPAT Pension & Annuity Phone #: 1-800-554-2479 Ext. 5533 Any questions on your pension and annuity, you must call this phone number.

SUMMARY OF MATERIAL MODIFICATION
TO THE PLAN OF BENEFITS
OF
PAINTERS DISTRICT COUNCIL NO.4
HEALTH & WELFARE FUND

A. General. This is a summary of material modification regarding the Plan of Benefits, Painters District Council No. 4 Health & Welfare Fund (the "Plan"). This summary of material modification supplements the Summary Plan Description (the "SPD") previously provided to you. You should retain this document with your copy of the SPD.

B. Sponsor Information. The legal name, address and federal employer identification number of the Sponsor are:

Board of Trustees
Painters District Council No. 4 Health & Welfare Fund
585 Aero Drive
Cheektowaga, NY 14225
EIN: 16-6070541

C. Summary Description of Modifications. The Trustees have approved the following changes to your Welfare Plan:

Effective January 1 2024, the Juneteenth holiday has been added as a paid day off under the Plan. Section 3 of Article V of the Plan has been amended to read as follows:

3. Vacation Benefits and Holiday Benefits

You are entitled to up to 6 vacation weeks per Plan Year (June 1 to May 31) and the following 10 holidays per calendar year: New Year's Day, Birthday of Martin Luther King, Jr., Memorial Day, Independence Day, Juneteenth National Independence Day, Labor Day, Veterans Day, Thanksgiving Day, Day After Thanksgiving, Christmas.

The amount of the journeyman benefit shall be $1,416.80 per five consecutive vacation days and $354.20 per holiday. Vacation and holiday benefits for Apprentices and Industrial Members shall be $752.60 per five consecutive vacation days and $354.20 per holiday. Your account will also be reduced by (as applicable) the employer Social Security, Medicare and unemployment taxes, so that the balance required in your account for five vacation days shall be $1,600 for a journeyman and $850 for an Industrial Members. Holidays require a $400 balance.

Claims for holiday and vacation benefits must be made within 60 days of the end of the Plan Year in which they accrue. The Trustees will presume that you are on vacation for any day you are not working for an Employer and for which you do not receive an Unemployment Benefit or Disability Benefit from the Fund.

These benefits are paid from your Wage Replacement Account and may not exceed the balance in your Account.

This notice constitutes your summary of material modifications as required by section 104(b) of ERISA and should be kept with your copy of the Plan's summary plan description and other important plan documents.

30928

HIGHMARK WESTERN NEW YORK

ENROLLMENT/WAIVER FORM

COMPLETE THIS APPLICATION IN ITS ENTIRETY IN BLUE OR BLACK INK. DO NOT USE PENCIL OR HIGHLIGHTER.

❑ **ENROLLING** (Complete sections I, II, IV, and V)

❑ **WAIVING** (Complete sections I and III)

I EMPLOYEE/CONTRACT HOLDER INFORMATION (Must be completed for both enrollees and waivers)

Effective Date	Employer/Group Name	Group Number	Payroll Location

First Name	MI	Last Name	Social Security Number *(If no SS#, write N/A)*

Address

City	State	Zip	County	Home/Cell Phone

Marital Status *(Please check one)*:
❑ Single/Widowed
❑ Married
❑ Divorced

Full-Time Hire (or Rehire) Date *(Month/Day/Year)*
_____/_____/_____

Enrollment Status
❑ Active Employee
❑ Rehired Employee
❑ Retiree
❑ HIPAA Life Event

Life Event
❑ COBRA Continuant Start Date _____/_____/_____
❑ Divorce
❑ Death of Spouse
❑ Loss of Student Status
❑ Dependent reached max age
❑ Left employ/retirement
❑ Add Dependent

Gender	Date of Birth *(Month/Day/Year)*	Age	Product Selection(s)
❑ M ❑ F ❑ U	/ /		❑ Medical Product Name: _____ ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Are you an Established Patient?
		❑ Yes ❑ No

II DEPENDENT INFORMATION (If enrolling more than four dependents, please attach a separate sheet.)

SPOUSE/DOMESTIC PARTNER

First Name	MI	Last Name	Relationship to You?
			❑ Spouse ❑ Domestic Partner †

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ M ❑ F ❑ U	/ /	

Product Selection(s):
❑ Medical ❑ Vision ❑ Dental

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Spouse/DP an Established Patient?
		❑ Yes ❑ No

† If your employer offers Domestic Partner coverage, please attach a Domestic Partner Affidavit and supporting documents to this application.

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child
			❑ Step-child ❑ Adopted* ❑ Other*

Social Security Number *(If no SS#, write N/A)*	Gender	Date of Birth *(Month/Day/Year)*	Age
	❑ Male ❑ Female	/ /	

Product Selection(s):	Dependent Status if Age 26 or Older
❑ Medical ❑ Vision ❑ Dental	❑ Disabled ❑ Act 4**

Full Name of Physician of Record (POR) Group Practice	POR Number from Provider Directory	Is Child an Established Patient?
		❑ Yes ❑ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

30928

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*
Social Security Number *(If no SS#, write N/A)*		Gender ❑ M ❑ F ❑ U	Date of Birth *(Month/Day/Year)* / / Age
Product Selection(s): ❑ Medical ❑ Vision ❑ Dental			Dependent Status if Age 26 or Older ❑ Disabled ❑ Act 4**
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No

DEPENDENT CHILD

First Name	MI	Last Name	Relationship to You? ❑ Child ❑ Step-child ❑ Adopted* ❑ Other*
Social Security Number *(If no SS#, write N/A)*		Gender ❑ M ❑ F ❑ U	Date of Birth *(Month/Day/Year)* / / Age
Product Selection(s): ❑ Medical ❑ Vision ❑ Dental			Dependent Status if Age 26 or Older ❑ Disabled ❑ Other
Full Name of Physician of Record (POR) Group Practice		POR Number from Provider Directory	Is Child an Established Patient? ❑ Yes ❑ No

*If enrolling an adopted child or a child that has been legally placed in your care, please attach a copy of the custodial/legal papers to support dependent eligibility.

III WAIVER OF COVERAGE (Complete this section ONLY if you are declining coverage(s) offered to you AND/OR your family members.)

MEDICAL

I HEREBY DECLINE MEDICAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**:
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

REASON FOR DECLINING MEDICAL COVERAGE:

- ❑ Insured under spouse
- ❑ Other

_____

VISION

I HEREBY DECLINE VISION COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

DENTAL

I HEREBY DECLINE DENTAL COVERAGE:

- ❑ For myself
- ❑ For family members **ONLY**
- ❑ For myself and **ALL** family members
- ❑ For the following family members:

_____

I hereby acknowledge that I have been given the opportunity to participate in the group insurance plan provided by my employer and that I have declined coverage formyself and/ormy dependents as noted above. If I and/or any of my eligible dependents desire to apply for this insurance at a later date, I may be required to wait until my group's renewal or until a special enrollment (described below) occurs before coverage will be offered.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed fivethousand dollars and the stated value of the claim for each such violation.

_____ _____

Employee/Contract Holder Signature Date

ONLY SIGN IF YOU ARE WAIVING COVERAGE

Special Enrollment Rights:

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may in the future be able to enroll yourself and your dependents in this plan, provided that you request enrollment within 30 days after you and your dependent's other coverage ends, or not later than 60 days if the other plan coverage was through Medicaid or a state Children's Health Insurance Program (CHIP). In addition, if you have a new eligible dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your eligible dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. To request special enrollment or obtain more information, contact your employer or call the toll-free Highmark Member Service number: 1-800-241-5704 (TTY/TDD: Dial 711).

IV OTHER HEALTH INSURANCE COVERAGE

Other Group or Non-Group Health Insurance Coverage

Name of Insurance Carrier	Group Number	Effective Date	Name of Policyholder
		/ /	

Policyholder Date of Birth	Relationship to Policyholder	Policy Number	Policyholder Employment Status
/ /			❑ Active ❑ Retired Date of Retirement: / /

Medicare Coverage (Please list any family member that is eligible for Medicare Benefits)

Name of Subscriber or Dependent	Health Insurance Claim Number	Effective Dates			Check (✓) Reason For Medicare Coverage			Medicare Supplement or Complement?
		Hospital (Part A)	Medical (Part B)	Prescription (Part D)	Age	Disability	End Stage Renal Disease	
								❑ Yes ❑ No
								❑ Yes ❑ No
								❑ Yes ❑ No

V IMPORTANT: AUTHORIZED SIGNATURE REQUIRED

I understand that this form enrolls those eligible persons listed above in the Products as described in the agreement between Highmark and my employer. I authorize any payroll deductions required for the coverage and recognize that I must formally enroll my dependents on this form or they will not be covered.

To the best of my knowledge and belief, the information provided on this application is true and correct.

I acknowledge and agree that any personally identifiable health information about me or my enrolled dependents ("Protected Health Information") is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and other privacy laws, and that, in accordance with those laws, Highmark may use and disclose Protected Health Information for payment, treatment and health care operations as described in its Notice of Privacy Practices. I understand that a copy of the Highmark Notice of Privacy Practices is available on the Highmark Web site, or from the Highmark Privacy Office.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Print Employee/Contract Holder Name

Print Employer/Group Name

Employee/Contract Holder Signature

Date

For New Group Business: Please send all new business materials (Small Group Business Application, Enrollment/Waiver Forms and all supporting documentation) to the appropriate Highmark Small Group Sales Contact.

For Ongoing Enrollment: If adding new employees/contract holders/or dependents to an existing group, please fax/send Enrollment/Waiver Forms to one of the following addresses:

Fax (866) 605-9524

enrollmentandbillinghighmarkny@highmark.com

Membership Department
P.O. Box 4208
Buffalo, NY 14240-4208

Notice of Nondiscrimination

The plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The plan provides:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, please call the customer service number on the back of your member ID card or contact the Civil Rights Coordinator.

If you believe that the plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Civil Rights Coordinator, PO Box 22492, Pittsburgh, PA 15222, Phone: 1-866-286-8295 (TTY 711), Fax: 1-412-544-2475, email: CivilRightsCoordinator@highmarkhealth.org

You can file a grievance in person or by mail, fax, or email. You can also file a civil rights complaint with the US Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at US Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TDD).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

For assistance in English, call the customer service number listed on your member ID card.

Para obtener asistencia en español, llame al servicio de atención al cliente al número que aparece en su tarjeta de identificación.

請撥打您 ID 卡上的客服號碼以尋求中文協助。

Обратитесь по номеру телефона обслуживания клиентов, указанному на Вашей идентификационной карточке, для помощи на русском языке.

פאר הילף אין אידיש, רופט די קאסטומער סערוויס אויפן נומער וואס שטייט אויף אייער ID קארטל.

বাংলায় সহায়তার জন্য, আপনার আইডি কার িডে তালকাভ ুক্ত নম্বর ্রে তা পররে বায় ান করুন।

한국어로 도움을 받고 싶으시면 ID 카드에 있는 고객 서비스 전화번호로 문의해 주십시오.

Aby uzyskać pomoc w języku polskim, należy zadzwonić do działu obsługi klienta pod numer podany na identyfikatorze.

اردو میں مدد کے لیے، کسٹمر سروس آپ کے شناختی کارڈ پر درج کردہ نمبر پر کال کریں

Pour une assistance en français, composez le numéro de téléphone du service à la clientèle figurant sur votre carte d'identification.

اردو زبان میں مدد کے لئے، کسٹمر سروس کو اپنے آئی ڈی کارڈ پر درج نمبر پر کال کریں.

Para sa tulong sa Tagalog, tumawag sa numero ng serbisyo sa customer na nasa inyong ID card.

Για βοήθεια στα ελληνικά, καλέστε το τμήμα εξυπηρέτησης πελατών στον αριθμό που αναφέρεται στην ταυτότητά σας.

Për ndihmë në gjuhën shqipe, merrni në telefon shërbimin klientor në numrin e renditur në kartën tuaj të identitetit.

Rele nimewo sèvis kliyantèl ki nan kat ID ou pou jwenn èd nan Kreyòl Ayisyen.

Per assistenza in italiano chiamate il numero del servizio clienti riportato nella vostra scheda identificativa.

Waiver of Group Health Benefits

Painters District Council No. 4 Health and Welfare Fund
585 Aero Dr., Cheektowaga, NY 14225 Ph: 716-565-0234 Fx: 716-565-1494

Please complete the following:

Participant Name: _____ _____ _____
(Last) (First) (MI)

Participant SS# (Last 4 digits): _____ Effective Date____/____/____
(MM/DD/YY)

I am waiving coverage for:

☐ Myself

☐ Spouse – (Name)_____

☐ Dependent (s) – Please list names:_____

Is this an employer sponsored plan? ☐ **Yes** ☐ **No**

I am waiving due to Coverage under:

☐ My own ☐ My spouse's ☐ My parent's plan

Name of carrier: _____

If you are waiving coverage, you must present a copy of your enrollment card.

☐ Other coverage – name of carrier: _____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formerly CHAMPUS)
☐ Child Health Plus ☐ Medicaid ☐ Indian Health Service

IMPORTANT: Individual coverage purchased through NY State of Health, Medicare, Medicaid, TRICARE, Child Health Plus or health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations are considered NON- Employer based plans and will not qualify for medical reimbursements.

****

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage.

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (60 days for Medicaid or a State Children's Health Insurance Program). If I do not do so, I will not be able to enroll until the plan's next annual open enrollment period (March 1st).

I understand that in order to request special enrollment due to a qualifying event or obtain more information, I should contact my group administrator.

_____ _____
Signature of Participant Date of Signature