Minnesota & North Dakota Bricklayers & Allied Craftworkers Health Fund

Retiree 2026 Enrollment and Authorization Form

P.O. Box 257 Minneapolis, Minnesota 55440-0257 651-256-1801 or 800-879-4412

See the Enrollment Guide for useful information. Please complete, sign, and return this form to the Fund Office. Print all information.

Employee Information

Retiree Full Name:______________________ Retiree SSN: ______________

Address:______________________ Home Phone #: ______________

City:______________ State:________ Zip Code:________ Alternate Phone #: ______________

Date of Birth:______________ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female

Email address:______________ Date ______ ______ ______

Health Plans Available

Check the Plan for yourself and your eligible dependents for 2026, you must indicate that election here and then sign the Retiree Authorization section of this form. If you miss the Open Enrollment deadline of November 17, 2025, you will remain in the same Plan as 2025. The monthly premium for full self-payments is shown for each plan and coverage level.

Plan Option	Annual Deductible Individual/Family	Single Coverage	EE + Children	EE + Spouse	Family
Plan A200	$200/$300	☐ $1,689	☐ $2,986	☐ $3,460	☐ $4,303
Plan B1000	$1,000/$1,500	☐ $1,422	☐ $2,517	☐ $2,917	☐ $3,628
Plan C2000	$2,000/$3,000	☐ $1,311	☐ $2,320	☐ $2,689	☐ $3,345
Plan D3000	$3,000/$4,500	☐ $1,231	☐ $2,178	☐ $2,523	☐ $3,140
Plan E4350	$4,350/$6,525	☐ $1,169	☐ $2,068	☐ $2,395	☐ $2,977

Dependent Information

Use this section to list your eligible dependents. **Attach an additional page if you need it**. Be sure to provide all requested information.

Spouse

Full Name:______________________ Spouse SSN: ______________

Date of Birth: ______________ Gender: ☐ Male ☐ Female

Dependent Child

Full Name:______________________ Dependent SSN: ______________

Date of Birth: ________ Gender: ☐ Male ☐ Female

Relationship to Employee: ☐ Natural Child ☐ Adopted Child ☐ Stepchild ☐ Other______________

Address (if different address than the participant): ______________________

City:______________ State:________ Zip Code: ________

Dependent Child

Full Name:______________________ Dependent SSN: ______________

Date of Birth: ________ Gender: ☐ Male ☐ Female

Relationship to Employee: ☐ Natural Child ☐ Adopted Child ☐ Stepchild ☐ Other______________

Address (if different address than the participant): ______________________

City:______________ State:________ Zip Code: ________

Dependent Child

Full Name:______________________ Dependent SSN: ______________

Date of Birth: ________ Gender: ☐ Male ☐ Female

Relationship to Employee: ☐ Natural Child ☐ Adopted Child ☐ Stepchild ☐ Other______________

Address (if different address than the participant): ______________________

City:______________ State:________ Zip Code: ________

Retiree Authorization

I understand this election will remain in effect from January 1, 2026 through December 31, 2026 and may only be changed as set forth in the *Notice of Special Enrollment Rights*. **I hereby certify that the foregoing information, to the best of my knowledge and belief, is true, correct, and complete. I understand any willfully false statement on this form is a federal crime that may be punishable by fine or imprisonment.**

Employee Name (print): ______________________

Employee's Signature:______________________ Date: ______________

Mail the completed form to the address at the top of this form.