

Date: \_\_\_\_\_

The Insurance Department  
TECU Credit Union

**TECU Members' Health Plan**

Member Number: \_\_\_\_\_

Member Name: \_\_\_\_\_

I hereby authorize **TECU CREDIT UNION** to deduct the health plan premium monthly from my member account.

Select the coverage option of your choice by checking the desired box:

DIVISIONS	MAJOR MEDICAL COVERAGE	ACTIVE Members age 64 and under		
		Member Only	Member + One Dependent	Member + Family
Division 1	\$250,000	<input type="checkbox"/> \$185.00	<input type="checkbox"/> \$333.00	<input type="checkbox"/> \$518.00
Division 2	\$400,000	<input type="checkbox"/> \$250.00	<input type="checkbox"/> \$450.00	<input type="checkbox"/> \$700.00
Division 3	\$750,000	<input type="checkbox"/> \$389.00	<input type="checkbox"/> \$700.00	<input type="checkbox"/> \$1,089.00
DIVISIONS	MAJOR MEDICAL COVERAGE	RETIREES Members age 65 and over		
		Member Only	Member + One Dependent	Member + Family
Division 4	\$250,000	<input type="checkbox"/> \$300.00	<input type="checkbox"/> \$540.00	<input type="checkbox"/> \$840.00
Division 5	\$400,000	<input type="checkbox"/> \$340.00	<input type="checkbox"/> \$612.00	<input type="checkbox"/> \$952.00
Division 6	\$750,000	<input type="checkbox"/> \$450.00	<input type="checkbox"/> \$810.00	<input type="checkbox"/> \$1,260.00

Member Signature: \_\_\_\_\_

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