IBEW LOCAL 351 WELFARE FUND

Application for Waiver of Retiree Health Insurance Coverage

Retiree's Name: _____

Waiver to be effective the first day of the month of _____ 20 __

Retiree's Social Security # ____ - ___ - _____ Retiree's Date of Birth ___ / ___ / _____

Date of Retirement ___ / ___ / _____

Spouse's Name: _____

Spouse's Social Security # ____ - ___ - _____ Spouse's Date of Birth ___ / ___ / _____

Source of Alternative Group Health Insurance Coverage:
_____
(Attach copy of valid identification card)

Alternative Group Insurance Carrier/Health Plan Name:
_____

Effective Date of Alternative Group Health Insurance Coverage: _____/_____/_____

Authorization:

By signing below I acknowledge that:

- I am eligible for coverage as a retired employee under the IBEW Local 351 Welfare Plan.
- I am enrolled under alternative group health insurance coverage.
- I voluntarily elect to discontinue my health insurance, prescription, dental and vision benefits for myself and my spouse and other eligible dependents under the IBEW Local 351 Welfare Plan.
- I have the right to re-enroll myself and my spouse and other eligible dependents for coverage under the IBEW Local 351 Welfare Plan. If I should die prior to re-enrolling, my spouse may also re-enroll for coverage.
- I may only re-enroll once, and then only during the month of December, with coverage becoming effective on the immediately following January 1st.

_____ _____
Signature of Retiree Date

_____ _____
Signature of Spouse Date