IBEW Local 400 Welfare Fund Retiree

Opt-Out Application for Retirees:

Medicare Advantage PPO Plan and/or Medicare Part D Prescription Drug Plan Coverage

This form is to be completed by each individual covered by the IBEW Local 400 Welfare Fund.

I,_____ request to **opt-out** of (check below):
Applicant First & Last Name

☐ Medicare Advantage PPO Plan Coverage

☐ Medicare Part D Prescription Plan Coverage

Applicant Relationship to the Plan:

☐ Retiree – Date of Retirement ____ / ____ / _____ **Status (select one):** ○ Married ○ Widowed ○ Single

☐ Spouse of a Retiree – Are You Actively Working? _____ If no, Date of Retirement ___ / ___ /_____

Social Security # _____ - ____ - _____ Date of Birth ____ / ____ / _____

Waiver to be effective the first day of the month of _____, 20 ___

Other Medical Insurance Plan Name: _____Eff. Date: _____/_____/____

Other Prescription Drug Insurance Plan Name:_____Eff. Date: ____/_____/____

A copy of all other insurance ID cards must be included with this form for both retiree and spouse (if applicable).

By signing below, I acknowledge that I:

- Am eligible for Medicare Advantage Plan and Medicare Part D Prescription coverage and voluntarily elect to opt-out of the coverage(s) I have selected above.
- Am retired under the IBEW Local 400 Pension Fund.
- Must notify the Fund Office if my other health insurance coverage terminates or another qualifying life event within 30 days of the qualifying event.
- Have a one-time election to re-enroll into the Welfare Fund benefits, prior to September 30th, with coverage becoming effective on the immediately following January 1st.

_____ _____
Applicant Signature Date