January 18, 2019

IBEW LOCAL 400 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 Health Insurance Coverage_____
(Attach copy of valid identification card)

Alternative Insurance Carrier/Health Plan Name:
_____

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

Authorization:
By signing below I acknowledge that:

- I am retired under the IBEW Local 400 Pension Fund.
- I am enrolled under alternative health insurance coverage.
- I voluntarily elect to discontinue health insurance coverage for myself and my dependents under the IBEW Local 400 Welfare Fund.
- I have the right to re-enroll myself and my dependent(s) for coverage under the IBEW Local 400 Welfare Fund. 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