PLUMBERS LOCAL 24 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 & Dental Insurance Coverage:
____
(Attach copy of valid identification card)

Alternative Insurance Carrier/Health Plan Name: ______________________________________

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

Authorization:

By signing below I acknowledge that:

- I am retired under the Plumbers Local 14 Pension Fund.
- I am enrolled under alternative health insurance coverage.
- I voluntarily elect to discontinue health insurance coverage for myself and my spouse under the Plumbers Local 24 Welfare Fund.
- I have the right to re-enroll myself and my spouse for coverage under the Plumbers Local 24 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