PLUMBERS & PIPEFITTERS LOCAL 9 WELFARE FUND

Waiver of Retiree Welfare Fund Coverage – Cease Applicable Contributions

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 Other Health & Dental Insurance Coverage: _____

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

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

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

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

By signing below, I acknowledge that I:

- Voluntarily elect to discontinue all the Plumbers & Pipefitters Local 9 Welfare Fund benefits *(medical, prescription, dental insurance coverage)* for myself and my spouse.
- **Understand I nor my spouse will not have any Welfare retiree benefits offered by the Welfare Fund** and eligible Welfare Fund retiree contributions shall cease.
- Am retired under the Plumbers and Pipefitters Local 9 Pension Fund.
- Am enrolled with other health insurance coverage outside of the Welfare Fund.
- Must notify the Fund Office if my other health insurance coverage terminates or another qualifying life event occurs within 30 days of the qualifying event.
- Have a right to a one-time election to re-enroll myself and my spouse for coverage under the Plumbers Local 9 Welfare Fund. If I should die prior to re-enrolling, my spouse may also re-enroll for coverage.
- Have a one-time election to re-enroll into the Welfare Fund retiree benefits, prior to September 30th, with coverage becoming effective on the immediately following January 1st.

_____ _____

Signature of Retiree Date

_____ _____

Signature of Spouse Date