PLUMBERS & PIPEFITTERS LOCAL 9 WELFARE FUND

Application for Waiver of Retiree Health & Dental 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 and Pipefitters Local 9 Pension Fund
- I am enrolled under alternative health and dental insurance coverage
- I voluntarily elect to discontinue health and dental insurance coverage for myself and my spouse under the Plumbers & Pipefitters Local 9 Welfare Fund
- I have the right 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.
- 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