

UFCW LOCAL 152 HEALTH & WELFARE FUND

27 Roland Avenue, Suite 100

Mount Laurel, NJ 08054

856-793-1598 (TTY:711) •800-555-4959 (TTY:711) •856-793-3100 (fax)

TUNNEL PLAN COVERAGE OPT-OUT FORM

EMPLOYEE INFORMATION				
Employee (Participant) Last Name	First Name/Middle Initial	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth / /	Social Security Number
Employee (Participant) Address	City / State / Zip			Phone Number
Name of Employer	<input type="checkbox"/> Full time <input type="checkbox"/> Part time	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced	Local Union Number	Date of Hire / /
Signature and Authorization to Permanently Terminate Coverage				
By signing this form, I permanently and completely terminate and waive current and/or future rights to coverage through UFCW Local 152 Health & Welfare Fund for myself and any eligible family members, if applicable. I understand that I am opting out of coverage for which I may otherwise be eligible, and that no money is due to me based on my decision to affirmatively opt-out of this coverage.				
Employee/Participant Signature _____			Date _____	