UNITED FOOD AND COMMERCIAL WORKERS UNION LOCAL 152 HEALTH AND WELFARE FUND

Brian String, Chairman
Daniel Dosenbach, Secretary

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Waiver of Coverage

You must complete, sign and return this form as indicated below if you want to waive coverage for yourself and/or my dependents. Use this form **only** if you wish to **waive** coverage under the **UFCW Local 152 Health and Welfare Fund** (the "Fund"). **If you do not wish to waive coverage for yourself and/or your dependents, you do not need to do anything and your Fund coverage will continue.**

I elect to WAIVE health coverage under the UFCW Local 152 Health and Welfare Fund for the following persons under the conditions set out below:

__myself (**Union contract must have opt out language to waive your own coverage)**

__my child(ren)

__my spouse

I certify that I have alternative health benefits for myself and/or my dependent(s) from the following source:

Name and relationship of person through whom
other coverage is obtained (e.g. self or spouse):_____
Name of employer/organization providing coverage: _____
Address of employer/organization: _____
Name and address of insurance carrier: _____
Policy/Group number: _____
Employee/subscriber identification number: _____

I understand that if I elect to WAIVE coverage under the Fund for myself and/or my dependent(s) I must furnish proof of alternative health coverage. Such proof may include, for example, a copy of an insurance identification card, a confirmation letter from the administrator of the other plan under which my dependent(s) is/are covered, or a HIPAA Certificate of Creditable Coverage. I understand that my waiver will not be approved without satisfactory proof of alternative coverage. I understand that I also must submit an Authorization for Release of Protected Health Insurance Information.

I understand that I and/or my dependent(s) is/are eligible for the benefits provided under the Fund. I understand that these benefits may include medical, hospital, major medical, dental, vision, and prescription drug coverage, as well as accidental death and dismemberment benefits. I certify that I voluntarily choose to waive all Fund coverage and benefits for myself and/or my eligible dependent(s) as noted above. I am doing so because I believe that I or my dependent(s) have alternative health benefits as identified above. I understand that my alternative medical coverage may not provide the same types and/or levels of benefits as the medical coverage provided under the Fund and that, depending upon the waiver I have identified above, I and/or my dependent(s) will have no coverage provided to them through the

Fund. In addition, I understand that I and/or my dependent(s) will not be permitted to re-apply for Fund medical and dependent coverage until the 1st of the month following 12 months from the date of this election. I understand that the Fund cannot confirm the alternative coverage identified above will be effective or guarantee myself and/or my dependents continued eligibility for the other coverage listed above, and the Fund is not responsible if I and/or my dependents lose the other coverage after waiving coverage under the Fund.

I understand that if I experience a life or family status change, I can elect to re-apply for coverage without waiting the 12 months following the date of this waiver. The effective date for a life or family status change is the date of the qualifying event. Life or family status changes include: marriage; divorce; death; birth; adoption/legal guardianship; or loss of eligibility for health coverage due to termination of employment.

Any life or family status changes must be reported to the Fund within 30 days of the qualifying event. Failure to report the event within the 30 days will disqualify me from re-applying for medical and dependent coverage in the Fund until 12 months following the date of this waiver.

HIPAA Special Enrollment Period

I acknowledge that I have been notified that HIPAA provides:

> If you decline enrollment for yourself or your dependents (including your spouse) under the Fund because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this Fund if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage). In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. To obtain special enrollment or for more information, contact the Fund Office at 1-800-555-4959.

I hereby voluntarily and freely waive all Fund coverage as identified above for the January 1-December 31 period following this election (or the balance of that period, if applicable) and hereby forever release the Fund and its Trustees, officers, employees, and agents, as well as UFCW Local 152 and its officers, employees, and agents, and my employer, its officers, employees, and agents from any and all liability as a result of my decision to waive Fund coverage for my dependents, including but not limited to, medical claims and expenses my dependents may incur during the period in which my waiver is effective. I further acknowledge that I have had an opportunity to review this waiver with legal counsel, and have either done so or have voluntarily chosen not to do so.

_____ Date: _____
Member Signature

Member SS# _____

Thank you,
Enrollment Department