# 4th District IBEW Health Fund

## Election to Decline Coverage Under the Retiree Benefit

**Retiree Name:** _____

**Social Security No.:** _____

**Address:** _____

_____

**Retirement Effective Date:** _____

I have elected to decline coverage under the retiree benefit of the 4th District IBEW Health Fund including, but not limited to, all dental, prescription drug and medical coverage under the 4th District IBEW Health Plan ("Plan") for myself and all eligible Dependents. I understand that by declining coverage, my eligible Dependents and I will not have any coverage through the Plan.

I certify that my eligible Dependents and I have medical coverage through

_____.
(group health plan)

Date:_____

Employee's Signature:_____

Spouse's Signature:_____

If you are declining enrollment for retiree coverage for yourself and your Dependents (including your spouse) because of other group health plan coverage, you may in the future be able to enroll yourself and your Dependents in the Plan, provided that your Dependents' other coverage ends for reasons other than fraud or failure to make the required payments and you request enrollment within 30 days after the other coverage ends. In addition, if you gain a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and those Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption. **Note:** When you reach Medicare eligibility age, you must reinstate coverage under the Plan. Failure to do so will result in the permanent declination of enrollment.

Please return this form to:

4th District IBEW Health Fund
9200 U.S. Route 60
Ona,, WV 25545