WAIVER OF COVERAGE

I, _____, S.S.N. _____, a participant in the Plumbers and Steamfitters Local No. 7 Welfare Fund do hereby elect, effective _____, 20___, to discontinue my health insurance coverages offered by Plumbers and Steamfitters Local No. 7 Welfare Fund, and to be placed on the "No Coverage Option" list.

I affirm that at this time I am covered under a group health insurance program provided by my spouse, or other, _____, whose employer is _____.
(Spouse's/other's Name) (Name of said Employer)

I understand that I must re-enroll for health insurance coverage and prescription drug coverage **immediately** should the coverage be terminated for any reason. I understand that I am still covered by disability and life insurance through Local No. 7 Welfare Fund and deductions will be made from my account monthly.

_____ _____
(Signature) (Date)

*** Please attach copies of **both sides** of any cards issued for Medical, Prescription Drug, Dental, and Vision Plans for which you may be enrolled

*** **Please fill in ALL sections; if you do not have coverage for dental and/or vision, please indicate same by writing 'none' in the space provided**

Plan Type	Insurance Carrier	Member ID	Group Number
Medical	_____	_____	_____
Prescription Drug	_____	_____	_____
Dental	_____	_____	_____
Vision	_____	_____	_____

*** Please provide the information below regarding the **Employer's Human Resources contact**

Human Resources Contact Name: _____

Telephone Number: _____ or E-mail: _____

***__This form must be updated each and every January. Failure to do so will result in a delay of reimbursement payments.__