PLUMBERS AND STEAMFITTERS LOCAL 21 WELFARE FUND

1024 McKinley Street, Peekskill, NY 10566 / Telephone: (914) 737-7220

OPT-IN FORM ACTIVE COVERAGE

PURPOSE OF THIS FORM – This form allows eligible members and dependents to opt back into medical benefits through the Plumbers and Steamfitters Local 21 Welfare Fund ("Fund"), subject to Plan requirements including the Plan's regular eligibility requirements. Members can opt-in only during the annual open-enrollment period or by having a qualifying event, such as the entitlement to a special enrollment period or the loss of their alternative employer sponsored group health coverage. This form must be properly completed, signed, and received by the Fund Office.

A. Member Information:			
Last Name		First Name	Middle Initial (MI)
Mailing Address			Social Security Number
City		State	Zip Code
Gender ☐ F ☐ M	Date of Birth: (Month/Day/Year)	Email Address	Phone Number

B. Opt-In Information: Complete this section for each person that is opting into welfare coverage. *Please provide appropriate documentation (social security card, birth certificate, marriage certificate, etc.)*

	Last Name	First Name	MI	Sex	DOB	SSN/ID Number
☐ Self (Member)						
☐ Spouse						
☐ Dependent Child						
☐ Dependent Child						
☐ Dependent Child						
☐ Dependent Child						

C. Signature & Acknowledgement:

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that I must request enrollment back into the Fund's medical plan within the applicable time period specified in the Summary Plan Description for special enrollment, or if for loss of alternative employer sponsored group health coverage, within 30 days after such coverage ends along with any required proof (e.g. termination letter from health plan or employer). I understand that if I fail to submit a request to opt back into the Fund's medical benefits within the applicable time frame, I will still be considered opted-out and I must wait until the next open enrollment period for coverage the next following calendar year even if I am eligible for benefits based on the Fund's regular eligibility rules. Furthermore, I understand that my entitlement to Fund benefits when I opt back in is based on having met the Fund's regular eligibility rules for coverage. I understand that Welfare Fund contributions will no longer be credited to my HRA account. I further acknowledge that the Trustees reserve the right and have the authority to amend, modify, and/or eliminate benefits, or to terminate the Plan at any time. The undersigned agrees to hold the Trustees of the Welfare Fund harmless from any and all claims, liabilities, damages, losses, or expenses arising out of or in connection with the undersigned's decision to opt out of the medical coverage. This hold harmless provision applies to any claims arising from a lack of medical coverage during the opted-out period, including but not limited to claims for medical expenses, injuries, or any other health-related issues.

Member's Signature_____ Date_____