# PLUMBERS AND STEAMFITTERS LOCAL 21 WELFARE FUND

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

## OPT-OUT FORM ACTIVE COVERAGE

**PURPOSE OF THIS FORM –** This form allows eligible members and dependents to opt-out of medical benefits through the Plumbers and Steamfitters Local 21 Welfare Fund ("Fund") and maintain the right to enroll at a later date, subject to Plan requirements. 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<br>☐ F ☐ M | Date of Birth: (Month/Day/Year) | Email Address | Phone Number |

**B. Opt-Out Information:** Complete this section for each person that is opting out of welfare coverage due to health coverage from another source.

| | 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 50% of my Welfare Fund contribution rate will be credited to my HRA account and 50% will be retained by the Welfare Fund, with a minimum retention of $4.50 per hour. I understand that I must provide proof of alternative employer sponsored group health coverage *(a copy of the group health insurance plan's Summary of Benefits and Coverage (SBC) and a copy of the group health insurance ID Card or a letter from the applicable employer confirming the group coverage and effective date*). I understand that I must provide proof of coverage annually during open enrollment. I understand that by opting out, I only remain eligible for the HRA, as well as the Welfare Fund's vision, life, accidental death and dismemberment insurance, employee assistance program, and supplemental disability benefits, and only to the extent I would otherwise be eligible for the Fund's medical benefits had I not opted out. (*This means that I must maintain enough hours to maintain eligibility for the aforementioned*). I understand that I can only opt back into the Fund's medical benefits annually during open enrollment or if I have a qualifying event entitling me to a special enrollment period, and if I opt back in, my entitlement to Fund benefits is based on having met the Fund's regular eligibility rules. Should I lose my alternative employer sponsored group coverage, I must notify the Fund Office and opt back into the plan within 30 days of losing the coverage. 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 acknowledge that they have voluntarily chosen to opt out of medical coverage. 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_____