WAIVER OF PARTICIPATION
IN THE
IBEW LOCAL 910 WELFARE FUND
GROUP HEALTH PLAN

I, the undersigned, a participant of the IBEW Local 910 Welfare Fund certify that I have been given an opportunity to enroll in the IBEW 910 Welfare Fund Health Plan Health Care Insurance Benefit. I understand that these benefits are offered to participants and their dependents. In order to waive automatic coverage, I must submit proof that I and/or my dependents are covered under my spouse's employer's health care plan or some other employer health care plan. Since I am covered under another plan, and after careful consideration, I have decided not to elect benefits as checked below.

I understand that by declining such coverage, I am forfeiting my right to recover and deductible, coinsurance, or non-covered allowable expenses that might be available to me or my dependents due to coordination of benefits with any other plan, except as allowed under the Personal Account Plan (PAP) Health Expense Benefit.

I understand that if I desire coverage in the future for myself or my dependents, I and my dependent(s) will only be able to late enroll for coverage under the following conditions:

- If I or my dependent are covered under another health plan and have an involuntary loss of coverage from the other plan; or

- If I acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption.

I and/or my dependents may late enroll provided I request enrollment within 30 days of a marriage, birth, adoption, or involuntary loss of coverage.

- If I have a change in family status (divorce, death of spouse etc.) as defined by this Plan provided I request enrollment within 30 days of the change in family status; or

- I may also late enroll my dependent(s) and myself under this Plan during the Open Enrollment Period.

I waive Coverage for:

Myself (Employee Coverage) ____

My Dependents* ____

* Must be waived if employee coverage is waived.

Please submit proof that you and/or your family are covered under your spouse's employer's health care plan or some other employer group health care plan. Further, you must demonstrate that such other coverage meets certain minimum standards.

_____ _____ _____

Print Name and Social Security # Signature of Participant Date