Waiver of Group Health Benefits

Painters District Council No. 4 Health and Welfare Fund
585 Aero Dr, Cheektowaga, NY 14225

Please complete the following:

Participant Name: _____ _____ _____
(Last) (First) (MI)

Participant SS# (Last 4 digits): _____

For the plan year effective ____/____/____ I am waiving coverage for:
(MM/DD/YY)

☐ Myself

☐ Spouse – (Name)_____

☐ Dependent (s) – Please list names:_____

_____

I am waiving coverage due to:

☐ Coverage under my spouse's/parent's plan – name of carrier: _____

Is this an Employer-Sponsored Group Plan? ☐ Yes ☐No

*****If you are waiving coverage, you must present a copy of your enrollment card and a letter from the employer stating who is covered on the plan and effective date.**

Please note that unless you are enrolled in coverage through Painters District Council No. 4 Health and Welfare Fund, or through an Employer-Sponsored Group Plan, you will not be eligible to submit any unreimbursed medical expenses or after tax premiums for payment from your Health Account.

☐ Other coverage – name of carrier: _____

This other coverage is: ☐ Individual ☐ COBRA ☐ Medicare ☐ TRICARE (formerly CHAMPUS)
☐ Child Health Plus ☐ Medicaid ☐ Indian Health Service

*****If you are waiving coverage, you must present a copy of your enrollment card.**

Individual coverage purchased through NY State of Health, Medicare, Medicaid, TRICARE or health programs operated by the Indian Health Service, Indian tribes, tribal organizations, and Urban Indian organizations will not qualify for medical reimbursements.

Special Enrollment Notice and Certification – *Please review and sign below if you wish to waive coverage*

By signing below, I certify that I have been given an opportunity to apply for coverage for myself and my eligible dependents, if any. I am declining enrollment as indicated above. I understand that I am declining enrollment for myself or my eligible dependents (including my spouse) because of other health insurance or group health plan coverage.

I understand that I must request enrollment no more than 30 days after the date the other health plan coverage ends (60 days for Medicaid or a State Children's Health Insurance Program). If I do not do so, I will not be able to enroll until the plan's next annual open enrollment period (March 1st).

I understand that in order to request special enrollment due to a qualifying event or obtain more information, I should contact my group administrator.

_____ _____
Signature of Participant Date of Signature