WAIVER OF COVERAGE

I _____, S. S. #_____,

a participant in the Plumbers and Steamfitters Local No. 7 Welfare Fund do hereby elect,

effective _____, to discontinue my health insurance

Coverages offered by Plumbers and Steamfitters Local No. 7 Welfare Fund, and be placed on the "No Coverage Option".

I affirm that at this time I am covered under a group health insurance program provided

by my spouse,_____ whose employer is
(spouse's name)

_____.
(spouse's employer)

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

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

_____ _____
(signature) (date)

******* Please provide the following additional information:

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

Human Resources Contact: _____

Telephone Number: _____

This form must be updated each January. Failure to do so will result in a delay of reimbursement payments.