CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

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RETIREE HEALTH BENEFITS CANCELLATION FORM – PARTICIPANT OR SPOUSE

The cancellation form must be returned to the Retirement Benefits Department by the fifteenth (15th) day of the month prior to the month that you wish to cancel coverage.

Participant's Name (PLEASE PRINT): _____

Participant's UID# or SS#: _____

If you cancel coverage, you may be allowed to re-enroll if you maintain continuous coverage with another plan. You will be required to provide evidence of continuous coverage in the event you enroll at a later date. Failure to provide evidence of continuous coverage means that you forfeit your rights for retiree coverage under the Chicago Regional Council of Carpenters Welfare Fund.

IMPORTANT: If an individual enrolls in dental or vision coverage, has services, and then cancels coverage before being enrolled in the coverage for at least one full year, the Trustees prohibit re-enrollment for a period of two years.

CHECK THE APPROPRIATE CIRCLE(S)

O I elect to CANCEL MY (the carpenter's) hospital and/or medical coverage. I understand that, if I have a spouse and/or other dependents covered under the hospital and/or medical coverage, this coverage will also be cancelled for them.

O I elect to CANCEL MY (the carpenter's) prescription drug coverage. I understand that, if I have a spouse and/or other dependents covered under the prescription drug coverage, this coverage will also be cancelled for them.

O I elect to CANCEL MY (the carpenter's) dental coverage. I understand that, if I have a spouse and/or other dependents covered under the dental coverage, this coverage will also be cancelled for them.

O I elect to CANCEL MY (the carpenter's) vision coverage. I understand that, if I have a spouse and/or other dependents covered under the vison coverage, this coverage will also be cancelled for them.

Spouse's Name _____

O I elect to CANCEL the hospital and/or medical coverage for MY SPOUSE.

O I elect to CANCEL the prescription drug coverage for MY SPOUSE.

O I elect to CANCEL the dental coverage for MY SPOUSE.

O I elect to CANCEL the vison coverage for MY SPOUSE.

Participant's Signature:_____

Date Signed by Participant:_____ (Rev 2/2017)