DENTAL CANCELLATION

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
RETIREE PLAN OF BENEFITS

12 East Erie Street, Attn: Retirement Benefits Dept., Chicago, Illinois 60611
Fax: (312) 951-3986 -- **Email:** pension@crccbenefits.org
Phone (312)787-9455, option #4

DENTAL BENEFITS APRIL 1, 2019 CANCELLATION FORM

Provided that this completed cancellation form is returned to the Retirement Benefits Department by March 15, 2019 (postmark date), dental benefits will be cancelled for April 1, 2019 in accordance with the elections made below.

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

Participant's Name (**PLEASE PRINT**): ____________________

Participant's UID# or SS#: ____________________

Participant's Street Address, City, State & Zip:____________________

Participant's Home Phone Number: ____________________ Cellular Phone Number: ____________________

Participant's E-Mail Address: ____________________

CHECK THE APPROPRIATE CIRCLE(S):

O Effective April 1, 2019 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 the dental coverage for my SPOUSE. **Spouse's Name** ____________________

O I elect to CANCEL the dental coverage for my DEPENDENT CHILD**. Dependent's Name** ____________________

O I elect to CANCEL the dental coverage for my DEPENDENT CHILD**. Dependent's Name** ____________________

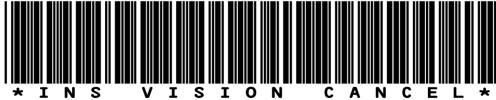
O I elect to CANCEL the dental coverage for my DEPENDENT CHILD**. Dependent's Name** ____________________

Participant's Signature:____________________

Date Signed by Participant:____________________

THIS FORM IS NOT VALID WITHOUT A SIGNATURE AND DATE

VISION CANCELLATION



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VISION BENEFITS APRIL 1, 2019 CANCELLATION FORM

Provided that this completed cancellation form is returned to the Retirement Benefits Department by March 15, 2019 (postmark date), vision benefits will be cancelled for April 1, 2019 in accordance with the elections made below.

If an individual received covered vison services, and then cancels coverage before being enrolled in vision coverage for at least one full year, the Trustees prohibit re-enrollment for a period of two years.

Participant's Name (**PLEASE PRINT**): ______________________________

Participant's UID# or SS#: ______________________________

Participant's Street Address, City, State & Zip:______________________________

Participant's Home Phone Number: ______________________ Cellular Phone Number: ______________________

Participant's E-Mail Address: ______________________________

CHECK THE APPROPRIATE CIRCLE(S):

O Effective April 1, 2019 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 vision coverage, this coverage will also be cancelled for them.

O I elect to CANCEL the vision coverage for my SPOUSE. **Spouse's Name** ______________________

O I elect to CANCEL the vision coverage for my DEPENDENT CHILD. **Dependent's Name** ______________________

O I elect to CANCEL the vision coverage for my DEPENDENT CHILD. **Dependent's Name** ______________________

O I elect to CANCEL the vison coverage for my DEPENDENT CHILD. **Dependent's Name** ______________________

Participant's Signature:______________________________

Date Signed by Participant:______________________________

THIS FORM IS NOT VALID WITHOUT A SIGNATURE AND DATE