



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, 2018 CANCELLATION FORM

Provided that this completed cancellation form is returned to the Retirement Benefits Department by March 15, 2018 (postmark date), dental benefits will be cancelled for April 1, 2018 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):

Effective April 1, 2018 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.

I elect to CANCEL the dental coverage for my SPOUSE. **Spouse's Name** _____

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

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

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, 2018 CANCELLATION FORM

Provided that this completed cancellation form is returned to the Retirement Benefits Department by March 15, 2018 (postmark date), vision benefits will be cancelled for April 1, 2018 in accordance with the elections made below.

If an individual received covered vision 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):

Effective April 1, 2018 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.

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

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

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

I elect to CANCEL the vision 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