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APPLICATION FOR SPOUSAL/DEPENDENT OPT-OUT OF COVERAGE FROM THE INDIANA LABORERS WELFARE FUND

Plan Participant Name: _____ Spouse's Name: _____

Plan Participant's SSN or Member ID: _____

I hereby request to terminate my spouse's coverage, as well as the listed dependents, under the Indiana Laborers Welfare Fund due to my spouse's eligibility under a high deductible health care plan with her/his current employer for which we are able to utilize a health savings account.

I wish to terminate coverage with the Indiana Laborers effective: _____

_____(spouse initial) I have attached proof of coverage with my employer.

_____(spouse initial) I understand that I can re-enroll in the Indiana Laborers Welfare Fund by providing proof of termination from the high deductible health care plan and health savings account through my employer.

_____(initial) I would like the following dependents removed from coverage in addition to my spouse. If this opt out is only for the spouse, leave this section blank.

Dependent Name	Birth Date	Relationship to Insured

By signing this form, I understand that myself and the dependents listed will no longer be eligible to receive benefits from the Indiana Laborers Welfare Fund until I formally re-enroll upon termination of my other coverage. Reenrollment will be contingent on my spouse being eligible under the Indiana Laborers Welfare Fund.

_____ _____

Signature of Spouse Signature of Plan Participant

_____ _____

Date Date

For Fund Office Use Only

Date approved by Plan: _____

Effective date of termination: _____