IBEW9 MSECA
Partners for Progress

Local Union No. 9, IBEW and Outside Contractors Health and Welfare Fund

Request for Spouse or Dependent Dis-Enrollment

I, _____, request to dis-enroll the following Spouse or Dependent from my Local Union No. 9, IBEW and Outside Contractors Health and Welfare Plan coverage. I understand that dis-enrollment itself and the effective date are subject to Fund Office approval.

Dependent Name	Relationship to Employee	Requested Last Day of Coverage (cannot be retroactive)	Reason for Dis-enrollment	Fund Office Use Only
Employee BCBSIL ID No.		Employee signature		

If a dependent child being dis-enrolled is <u>under the age of 18</u>, both of the dependent's parents or guardians must authorize the dis-enrollment by signing this form in the presence of a Notary Public.

_____ _____ _____
Parent or Guardian No. 1 Printed Name Parent or Guardian No. 1 Signature Date

I hereby acknowledge that _____, whose identity I verified by (check one) ___*personal acquaintance* or ___ *government-issued identification in the form of* _____, *ID No.* _____, personally signed this document in my presence on the date hereinafter written.

_____ _____ Affix Notary Seal here
Notary Public Signature Date

_____ _____ _____
Parent or Guardian No. 2 Printed Name Parent or Guardian No. 2 Signature Date

I hereby acknowledge that _____, whose identity I verified by (check one) ___*personal acquaintance* or ___ *government-issued identification in the form of* _____, *ID No.* _____, personally signed this document in my presence on the date hereinafter written.

_____ _____ Affix Notary Seal here
Notary Public Signature Date

If a dependent child being dis-enrolled is <u>over the age of 18</u>, the dependent must authorize the dis-enrollment by signing this form in the presence of a Notary Public.

_____ _____ _____
Dependent Printed Name Dependent Signature Date

I hereby acknowledge that _____, whose identity I verified by (check one) ___*personal acquaintance* or ___ *government-issued identification in the form of* _____, *ID No.* _____, personally signed this document in my presence on the date hereinafter written.

_____ _____ Affix Notary Seal here
Notary Public Signature Date

*Re-Enrollment option on the back of this page

Request for Dependent Re-Enrollment

I, _____, hereby request to re-enroll the following Dependent(s) on my Local Union No. 9, IBEW and Outside Contractors Health and Welfare Plan. I understand that re-enrollment is subject to all of the following:

a) I must do so in writing by using this form,
b) the Dependent must meet the definition of Dependent as defined by the Plan,
c) I may be required to provide further documentation to the Fund Office,
d) the effective date of re-enrollment is subject to Fund Office approval,
e) the Fund Office may reject re-enrollment.

Dependent Name	Relationship to Employee	Requested Re-Enrollment Date (cannot be retroactive)	Reason for Re-Enrollment	Fund Office Use Only
Employee signature			Date	
Employee BCBSIL ID No.				