WAIVER (OPT OUT) OF PARTICIPATION IN THE IBEW LOCAL 43 WELFARE FUND GROUP HEALTH PLAN

I, the undersigned, a participant of the IBEW Local 43 Welfare Fund certify that I have been given an opportunity to enroll or am currently enrolled for the health insurance benefit in the IBEW 43 and Electrical Contractors Health & Welfare Fund. I understand that this benefit is offered to participants and their dependents. In order to waive or "opt out" of automatic coverage for the health insurance benefit: (1) I must prove that I am covered under my spouse's employer's health care plan or some other employer health care plan that provides "minimum value"; and (2) the Trustees must determine that the submitted other health care plan meets certain standards; a determination that is solely in the discretion of the Trustees or their delegee. An employer-sponsored health plan meets the "minimum value standard" if that plan's share of the total allowed benefit costs covered by that plan is no less than 60 percent of such costs. Since I am covered under another plan that provides minimum value, and after careful consideration, I have decided not to elect the Fund's health insurance benefit as initialed below.

I understand that if I have eligible dependents and elect Single coverage, I must prove that my dependents are covered by my spouse's employer's health plan that provides minimum value.

I understand that by declining such coverage, I am forfeiting my right to recover medical benefits or any deductible, coinsurance, or non-covered allowable expenses that might be available to me or my dependents due to coordination of benefits with any other plan, except as allowed under the Health Reimbursement Account Plan (HRA) Benefit.

I understand that if I desire coverage in the future for myself or my dependents, I and my dependent(s) will only be able to late enroll for this coverage under the following conditions:

1. If I or my dependent are covered under another health plan and have an involuntary loss of coverage from the other plan; or

2. If I acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption.

   I and/or my dependents may late enroll provided I request enrollment within 30 days of a marriage, birth, adoption, or involuntary loss of coverage.

3. If I have a change in family status (divorce, death of spouse, etc.) as defined by this Plan provided I request enrollment within 30 days of the change in family status; or

4. I may also late enroll my dependent(s) and myself under this Plan during the Open Enrollment Period.

I WAIVE MEDICAL COVERAGE ONLY FOR:

Myself (Employee Coverage) and dependents ____ (Initial)

Only My Dependents (spouse and children as described in the Summary Plan Description) ____ (Initial)

If you are opting out, you must submit a copy of your current Group Health Insurance plan's ***Summary of Benefits and Coverage** as proof that the plan meets the "minimum value" and a photocopy of the current Group Health Insurance ID Card or, if the above documentation is not available, a letter from the employer confirming the coverage. The Trustees may require that you provide a copy of that insurance policy. If you are electing Single coverage, or if you are opting out and want your HRA allocations to be available for qualifying expenses incurred by eligible dependents, you must submit the above evidence of group coverage for any eligible dependents.

By signing this form, I also acknowledge that I have been notified of, but choose not to elect, the option (available annually) to permanently "opt out" of all medical coverage and Health Reimbursement Account benefits offered through the Fund. I further acknowledge that I am not waiving all future reimbursements from my personal account

_____	_____	_____
Print Name and Social Security #	Signature of Participant	Date