IAMAW DISTRICT 15 HEALTH FUND

WAIVER OF BENEFITS

The undersigned employee hereby certifies to the IAMAW District 15 Health Fund (the "Health Fund") that:

I received descriptive materials, booklets and details about the benefits available under the Fund to me (and my eligible dependents). I understand these benefits and have had an opportunity to consider these benefits and ask questions about them.

I understand that under the terms of the current collective bargaining agreement between IAMAW District 15 and my employer, ____________________________, I may, subject to any limitations contained in the collective bargaining agreement and/or the Health Fund, choose to waive coverage under the Health Fund if I (a) pay all or part of the contribution rate for coverage and (b) have medical coverage through my spouse or another employer and provide proof of such coverage. I understand that I may not waive coverage if the contribution rate is fully paid by my employer.

In order to waive coverage I must complete and return this Waiver of Benefits form, together with proof of other medical coverage, to the Health Fund Office within 30 days of the date I would have been eligible under the Health Fund, or if currently enrolled, within 30 days of the date I am first offered the opportunity to waive coverage due to a change in the collective bargaining agreement, in which case participation in the Health Fund will cease as of the first of the month that is at least 30 days after the date proof of other coverage is provided to the Health Fund.

After serious consideration, I voluntarily elect to waive coverage under the Health Fund for myself (and my eligible dependents) and certify that I (and my eligible dependents) have employment-related coverage for health care through my spouse or another employer from ____________________________________ (Attach documentary proof of other coverage).

I understand that under the following circumstances I have the right to specially enroll in the Health Fund:

- If I (or my eligible dependents) involuntarily lose coverage under the other plan listed above because of legal separation, divorce, death, termination of employment, reduction in hours of employment, loss of dependent status, loss of eligibility status under the plan, termination of employer contributions toward such coverage, or exhaustion of COBRA coverage. Loss of coverage due to a failure to timely pay employee premiums or for cause is not considered involuntary. **To be specially enrolled due to a loss of other coverage I must submit an application for enrollment to the Health Fund, together with proof of loss of coverage, within 30 days after the other coverage ends.** Coverage under the Health Fund will be effective the first of the month following receipt by the Fund of the request for special enrollment.

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- If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself, my spouse and/or my dependents in the Fund, provided that I **submit an application for enrollment to the Health Fund within 30 days after the marriage, birth, adoption, or placement for adoption**. Coverage under the Health Fund will be effective as of the first of the month following receipt by the Health Fund of the request for special enrollment in the case of marriage, or retroactively to when the birth, adoption or placement occurred, provided a request for special enrollment is timely provided to the Health Fund.
- If I and/or my dependents are covered under Medicaid or a state Children's Health Insurance Program (CHIP) and later lose eligibility for such coverage, or become eligible for Medicaid or CHIP premium assistance toward coverage under the Fund, I may be able to enroll myself, my spouse and/or my dependents in the Health Fund, provided that I **request enrollment within 60 days after the loss of coverage or becoming eligible for premium assistance.**

I hereby waive and release these benefits and privileges knowingly and voluntarily under my own free will and will not hold my Employer, the Union or the Fund and/or each of their officers, trustees, employees, agents or representatives, responsible for, or liable for any claims for coverage that would have been or may be available if I (and my eligible dependents) were participating in the Health Fund. This waiver and release shall be binding on my heirs, assigns and representatives.

______________________	______________________
EMPLOYEE'S NAME	EMPLOYEE'S SIGNATURE
DATE: ______________	SOCIAL SECURITY # ____________

______________________	______________________
SPOUSE'S NAME	SPOUSE'S SIGNATURE
DATE: ______________	SOCIAL SECURITY # ____________

I.A.M. District No. 15
Health Fund

EMPLOYER VERIFICATION FORM

Employer Name: ______________________________________

Address: ______________________________________

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Re: Employee's Name: ______________________________________

The Employer hereby certifies to the IAMAW District 15 Health Fund that the above named employee is in the bargaining unit represented by the Union; that the employee has been advised of his rights and options with respect to participation in the IAMAW District 15 Health Fund and has had an opportunity to consider the benefits available under the IAMAW District 15 Health Fund; that there has been no promise of or grant of benefits in exchange for the employee's waiver, except as may be provided for in the Union contract; and that the employee may be able to enroll in the Fund under certain circumstances pursuant to the Rules and Regulations adopted by the IAMAW District 15 Health Fund.

The Employer acknowledges and agrees that notwithstanding the employee's waiver of coverage under the IAMAW District 15 Health Fund the Employer has a continuing obligation to contribute to the IAMAW District 15 Health Fund to the extent provided under the terms of the Union contract

By: ______________________________________

Date: ____________________

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I.A.M. District No. 15
Health Fund

APPLICATION FOR SPECIAL ENROLLMENT*
IN
IAMAW DISTRICT 15 HEALTH FUND

In accordance with the voluntary opt-out program under the collective bargaining agreement between ____________________________ and IAMAW District 15, I certify that:

___I (or my eligible dependents) no longer have other health coverage through ________________________ (attach documentary proof of loss of other coverage)

__ I am newly married (attach copy of marriage certificate)

__ I have a new dependent child (attach copy of birth certificate, adoption papers, placement papers)

__ I (or my eligible dependents) am no longer eligible for Medicaid or a state Children's Health Insurance Program (attach proof of loss of eligibility)

__ I (or my eligible dependents) am eligible for premium assistance under Medicaid or a state Children's Health Insurance Program (attach proof of eligibility)

I hereby apply for enrollment in the IAMAW District 15 Health Fund effective the first day of the month following receipt of this Application for Enrollment by the Health Fund Office (or retroactively for a dependent child). I understand that I will not be eligible for coverage if this Application is not timely filed with the Health Fund.

______________________________ ______________________________

Employee Name Employee Signature

Date: _______________ Social Security #:_____________________

Witness: ______________________________

*** This Application for Enrollment must be received by the Health Fund Office within 30 days of your loss of other coverage, marriage, birth, adoption or placement of a child for adoption; or within 60 days of losing eligibility for Medicaid or state Children's Health Insurance Program or becoming eligible to receive premium assistance under Medicaid or state Children's Health Insurance Program.**

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