SOUTH CENTRAL MINNESOTA ELECTRICAL WORKERS FAMILY HEALTH PLAN
c/o Wilson-McShane Corporation, Mail Stop 1
3001 Metro Drive, Suite 500 • Bloomington, MN 55425
Phone: 1-800-535-6373 • Fax: 952-854-1632

Application to Waive Coverage for Major Medical Benefits In Favor of Other Available Coverage

I hereby apply to waive coverage and availability of Major Medical Benefits and Prescription Drug Benefits under the South Central Minnesota Electrical Workers Family Health Plan (the "Plan") for myself and all of my Dependents.

Name of employee covered or eligible for coverage under the Plan:

____

Address: ____

Date of Birth: ____

Name of each Dependent covered or eligible for coverage under the Plan: ____________________

____

Address of Dependents (if different from above): ___________________________

____

Name of Spouse's Employer-Sponsored Health Plan in which I am enrolled or will be enrolled on the effective date of my waiver:

____

I hereby certify that I am currently enrolled in or, prior to the effective date of my waiver, will be enrolled in my spouse's employer-sponsored health plan or a government-sponsored health plan and have **attached to this application true and accurate evidence of my enrollment in my spouse's employer-sponsored health plan or government-sponsored health plan.** I understand that by executing this form:

- I am waiving any and all rights that my Dependents and I may otherwise have to participate in or be eligible for Major Medical Benefits or Prescription Drug Benefits under the Plan;
- The Plan will charge my Premium Credit Account a premium for continued eligibility for Life Benefits, Weekly Income Disability Benefits, and for continuing to accrue eligibility for Retiree Benefits. If my Premium Credit Account is not sufficient, I will be required to make a self-payment to continue these benefits;
- During my waiver period, I will continue to be eligible to participate in the Plan's Health Reimbursement Arrangement, the Life Benefit, and the Weekly Income Disability Benefit and to accrue eligibility for Retiree Benefits under the Plan as long as the premium is paid;
- The Trustees have the authority to discontinue all waivers at any time and require me to immediately re-enroll in the Plan;
- I will not otherwise be allowed to re-enroll (for myself or any of my Dependents) for Major Medical Benefits or Prescription Drug Benefits unless (a) I either lose coverage under my spouse's employer-sponsored health plan or TRICARE (and re-enroll within 30 days thereafter) or enroll during the Plan's open enrollment period (December 1 – 31 of each year), (b) I meet the eligibility requirements of the Plan, and (c) my application to re-enroll is accepted by the Trustees.

I request that my waiver of coverage be effective on ______________________. If it is granted, this waiver will remain in effect unless and until I re-enroll as permitted by above.

Date:______________________ ________________________________

Signature of Employee Waiving Coverage