

SOUTH CENTRAL MINNESOTA ELECTRICAL WORKERS FAMILY HEALTH PLAN

c/o Wilson-McShane Corporation

1330 Conway St, Suite 130 • St. Paul, MN 55106

Phone: 1-800-535-6373, 952-854-0795 • Fax: 651-776-9973

**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 or Government-Sponsored 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 is 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