Toledo Electrical Welfare Fund

Waiver of Participation

Surviving Spouse

I hereby waive medical and prescription drug coverage under the Toledo Electrical Welfare Fund for myself and/or my family member.

Affirmation of Alternate Coverage

I affirm that I and/or my spouse and any dependents, have core medical coverage under another plan (e.g., a medical plan) The alternate coverage is provided though:

Relative Name: _____

Relation: _____

Employer: _____

Plan Carrier / Administrator: _____

Effective Date: _____

I understand that if I decide to enroll or add family members at a later date that I and/or my eligible family will be subject to the policies and procedures of the Toledo Electrical Welfare Fund.

I also understand that this election is irrevocable during the Plan year and may only be changed in the event of a change in family status such as; legal marriage, divorce, birth or adoption of a child, and termination of employment of a spouse (see pages 1 and 2 for a complete list). Should I wish to change my election for further Plan years, I am required to submit a new election form by January 1 of each year. Otherwise, election will automatically renew until such time.

Signed:

Date: