Toledo Electrical Welfare Fund

Opt-Out of Participation

Surviving Spouse

I hereby opt-out and waive medical, dental, vision and prescription drug coverages under the Toledo Electrical Welfare Fund for myself and any of my covered dependents.

Affirmation of Alternate Coverage

I affirm that myself and all of my covered dependents have group medical coverage under another employer's plan. This alternate coverage is provided though:

Plan Name: _____

Employer: _____

Cardholder Name: _____

Plan Carrier / Administrator: _____

Effective Date: _____

I understand that this election is irrevocable and may only be changed in the event of a change in family status, such as: my marriage, divorce, birth or adoption of a child, and/or involuntary loss of this alternate coverage, and then only if I elect to opt back in to coverage within 31 days of the date of the change in family status. Please refer to the Fund's Summary Plan Description booklet for additional information.

Signed:

Date: