EWBTF
Electrical Workers Benefit Trust Fund

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1828 North Meridian Street – Suite 103, Indianapolis, IN 46202

MEDICARE OPT – OUT

Participant Section
Participant's Name:
Social Security Number:
Date of Birth:
Address:
City, State Zip:
Phone Number:
Email Address:
Date you wish to terminate coverage:

Notary Section

STATE OF _____

SS:

COUNTY OF _____

Before me, the undersigned, a Notary Public for _____ County, State of _____, personally appeared_____ and acknowledged the execution of this document this _____day of 20_____.

_____

Signature of Notary Public

_____

Printed Name of Notary Public

My Commission Expires _____

I am requesting termination from the Electrical Workers Benefit Trust Fund effective the date listed above. I understand that myself and my dependents will no longer have medical, dental, vision or prescription benefits through the Electrical Workers Benefit Trust Fund. I understand that once coverage is terminated, I CANNOT enroll at a later date.

Signature:	**Date:**