EWBTF
Electrical Workers Benefit Trust Fund

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

DEPENDENT OPT – OUT

Dependent Section	
Participant's Name:	**SSN:**
Dependent's Name	**Relation:**
Date you wish to terminate coverage:	

	Acknowledgements – Please Initial
	I request to opt out of coverage under the Electrical Workers Benefit Trust Fund due to eligibility under a high deductible health care plan with my current employer
	I have attached proof of coverage with my employer
	I understand that I can enroll in the Electrical Workers Benefit Trust Fund by providing proof of termination from the high deductible plan through my employer

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 _____

By signing this form, I am requesting termination from the Electrical Workers Benefit Trust Fund effective the date listed above. I understand that I will no longer have medical, dental, vision or prescription benefits through the Electrical Workers Benefit Trust Fund. I understand that enrollment will be contingent on the Plan Participant being eligible under the Electrical Workers Benefit Trust Fund.

Dependent's Signature:	**Date:**
Participant's Signature:	**Date:**