# Roofers' Local #195
# Health, Accident & Pension Funds

7706 Maltlage Drive Liverpool, NY 13090
Phone: (315) 699-1388 Fax: (315) 699-1390


## Spousal Insurance Option Election/Rejection Form

Participant Full Name: _____

Spouse Full Name: _____

Phone: (_____) _____ Alt Phone: (_____) _____

Email Address: _____

Dear Spouse:

This letter is to inform you of your insurance options due to the implementation of the Spousal Insurance Opt-Out Rule.

Your Spousal Insurance Opt-Out Form indicates that you fall within the guidelines established by the Fund Office, which require you to purchase ***medical only*** health insurance ***for yourself***. Our Fund coordinates plans regardless of whether your spouse elects his/her employers health coverage.

In the event that you do not wish to purchase/acquire your own medical coverage through your employer, you will be required to submit a Summary Plan Description which contains a detailed outline of the medical coverage's you have refused, so that we may coordinate benefits just as though your insurance were in effect and primary on you. In other words, we will be making the co-pays just as though you had purchased the medical insurance policy on yourself, from your employer, and you will be responsible for the balances, which would have otherwise been covered by your insurance.

_____Check here if you have elected to purchase/acquire medical coverage with your employer. Please attach copies of your insurance cards and indicate what coverage's you have chosen by checking all that apply:

| | | | |
|---|---|---|---|
| Medical: | _____Family | _____Self | Effective Date:_____ |
| Dental: | _____Family | _____Self | Effective Date:_____ |
| Prescription: | _____Family | _____Self | Effective Date:_____ |
| Vision: | _____Family | _____Self | Effective Date:_____ |

_____Check here if you have chosen not to purchase/acquire medical coverage with your employer. ***Please enclose a copy of your Plan Summary Description Booklet so that we may coordinate claims accordingly.***

***No claims will be processed, effective immediately, without this Coordination of Benefits information on file.***

Spouse Signature:_____Date:_____

Sincerely,
The Fund Office Staff