INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
Telephone (812) 238-2551 Fax (812) 238-2553
www.indianalaborers.org

Class A – Active Coverage Opt Out Form for Spouse and Adult Dependent Children (Age 18-26)

This form MUST be completed and signed by the Participant in the presence of a Notary Public.

Participant Name: _____

Participant SSN or Member ID: _____

In the table below,* please list who you would like to remove from your health coverage:

Name	Date of Birth	Spouse or Child?

* If you wish to remove more than 3 individuals, please use the back of this form.

******You MUST submit proof of other health coverage for the spouse/child(ren) listed above with this form, or else it will be considered invalid.******

I hereby request that health coverage under the Indiana Laborers Welfare Fund be terminated for the individual(s) listed above. The individual(s) have other health coverage through a policy or group health plan other than Medicaid or Medicare. I understand that the Indiana Laborers Welfare Fund will not be responsible for payment of any claims denied by Medicaid or Medicare based on a false representation to Medicaid or Medicare that coverage under the Indiana Laborers Welfare Fund was unavailable.

I understand that the individual(s) listed will no longer be eligible to receive any healthcare benefits available through the Indiana Laborers Welfare Fund, effective the 1st day of the month after the Fund Office approves this request. The Fund will provide written notice of the removal to each of the individual(s).

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RE-ENROLLMENT: I understand the individual(s) may only reenroll for health coverage under the Indiana Laborers Welfare Fund, the earliest of December 1st of any Plan Year, or after experiencing a Qualifying Event as defined in Section 3.06 of the Summary Plan Description.

Participant: _____ _____
(Member) Signature Date

I, _____ Notary Public, hereby certify that the signature above is of the person appearing before me and have executed the foregoing document of their own free will.

STATE OF)
) SS:
COUNTY OF)

Dated this_____day of_____, 20_____

_____
Signature of Notary Public

My Commission Expires: _____

County of Residence: _____

Fund Office Use Only

Coordination of Benefits Other health coverage shows active: ☐ Yes ☐ No

Date approved by Plan: _____ Effective date of termination: _____

Date notice provided to individual(s): _____

_____ _____
Signature of Plan Representative Date