Proof of Other Coverage Form

Complete This Form To Opt-Out of Medical Coverage

In order to waive coverage, you must complete this form to provide proof that you have other medical coverage
Note: You do not need to complete this form if you're waiving dental coverage only.

Please complete this form ONLY IF you elect "Opt-Out" as your medical plan choice. Attach a copy of the identification card from your other insurance coverage.

Please return this form, along with your enrollment form, to the Fund office. Thank you for your cooperation.

My other medical coverage is provided through:

Employer Name or Plan:

_____

The insurance carrier is: (for example, Blue Cross/Blue Shield or HMO name)

_____

Your Authorization

By signing this form, I am rejecting the medical coverage offered under the SEIU Local 32 BJ, District 36 BOLR Welfare Fund 36Phlex Plan and certify that I have the medical coverage indicated above.

Your Signature _____ Date_____

Please print name _____

Special Enrollment Rights

You may enroll for medical coverage during the year if you get married, acquire a new dependent, or lose your other medical coverage. To be eligible for this special enrollment, you must send a written request to the Fund Office within 31 days of the event.

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