Proof of Other Coverage Form SEIU Local 32BJ, District 36 BO Welfare Plan

Complete This Form To Opt-Out of Coverage for Dependents Only.

In order to waive coverage for your dependent(s), you must complete this form and provide proof that the dependent(s) who you are not enrolling has/have coverage elsewhere.

Attach a copy of the identification card from your other insurance coverage.

Please return this form to the Fund office. Thank you for your cooperation.

Coverage is provided through:

Employer Name or Plan: _____

If you have separate coverage for medical, prescription, dental and vision please provide copies of insurance for each plan.

Your Authorization

By signing this form, I am rejecting the coverage offered under the SEIU Local 32BJ, District 36 BOLR Welfare Fund and certify that my dependent(s) has/have the coverage indicated above.

Please list the names and dates of birth of the dependent(s) you are disenrolling:

_____ _____
Dependent's Name Date of Birth

_____ _____
Dependent's Name Date of Birth

_____ _____
Participant's Signature Date

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 along with appropriate documentation to the Fund Office within 31 days of the event.

SEIU Local 32BJ, District 36 BOLR Welfare Fund

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