Heat & Frost Insulators Local 17 Benefit Funds

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Pensioner's Name_____ Soc. Sec. # _____

_____ I authorize the Fund to deduct the monthly premium(s) for medical and optical benefits from my monthly pension benefit check for the following eligible person(s):

( ) Retiree only ( ) Retiree and Spouse- Spouse's Name _____
( ) Survivor
( ) Dependent Name _____ Birth Date _____
Name _____ Birth Date _____
Name _____ Birth Date _____

Signature _____ Date _____

_____ I elect to waive medical and optical benefits for my spouse at this time due to coverage under an Other Plan. I understand I may request my spouse to be enrolled for Coverage in advance at the time of termination of Other Coverage. Written documentation from Spouse's employer indicating termination of Other Coverage must be submitted immediately, otherwise Coverage under this Plan will not be provided.

Signature _____ Date _____

_____ I reject the medical and optical Plan coverage and elect to purchase and submit monthly payments for C.O.B.R.A health coverage, for 18 or 36 months. Upon termination of C.O.B.R.A coverage, I understand that I will not be eligible to elect other medical and optical coverage under the Plan. The C.O.B.R.A coverage is for the following eligible person(s):

( ) Retiree ( ) Retiree and Spouse- Spouse's Name _____
( ) Survivor
( ) Dependent: Name _____ Birth Date _____
Name _____ Birth Date _____
Name _____ Birth Date _____

Signature _____ Date _____

_____ I elect not to purchase either the C.O.B.R.A coverage or the Plan medical and optical coverage. I understand that I will not be eligible to purchase health coverage at a future date.

Signature _____ Date _____