

## **ELECTION AND WAIVER OF BENEFITS**

I, the undersigned, have been informed that I am eligible for the following coverage through the National IAM Benefit Trust Fund (*only those marked with an x*):

Medical	Dental	Vision
Short Term Disability	Life and AD&D	

I understand that my employer,

payroll deductions toward the cost of some or all of this coverage.

I elect to take or waive coverage through the National IAM Benefit Trust Fund as follows (*complete this section only for the eligible coverage types that are marked above*):

Coverage Type	I want this coverage	I do not want this coverage	I have other group coverage of this type
Medical	Elect Coverage	Waive Coverage	Yes No
Dental	Elect Coverage	Waive Coverage	Yes No
Vision	Elect Coverage	Waive Coverage	Yes No
Short Term Disability	Elect Coverage	Waive Coverage	Yes No
Life and AD&D	Elect Coverage	Waive Coverage	Yes No

If I waive any coverage for myself or my dependents, I understand that I will not be entitled to reinstate that coverage through the National IAM Benefit Trust Fund until my employer's annual open enrollment period (or if my employer does not have an open enrollment period, an annual enrollment period assigned by the Benefit Trust Fund).

However, I understand that I may specially enroll before my employer's open enrollment period (*or assigned annual enrollment period*) if I am declining any coverage because I am currently covered by another group health plan as an employee, retiree, or dependent, and that coverage is later terminated because of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of employer contributions toward the cost of the other coverage, an increase in the subscriber's cost for the other coverage, or the exhaustion of COBRA coverage.

I further understand that if my other coverage is exhausted for any of the above reasons, I must provide evidence of such termination to the National IAM Benefit Trust Fund, and request a special enrollment no later than **30 days** after the date my other coverage is exhausted.

Employee Name – Please Print

Social Security Number

may make

Employee Signature

Date Signed