DANIEL H. COOK
ASSOCIATES INC

Member Opt-out Form

Group Name: Sheet Metal Worker's Local No. 40 Health Fund

Please use this form if you wish to opt out of your Sheet Metal Workers' Local No. 40 Health Fund ("Fund") coverage for yourself and your eligible dependent(s). This form must be filled out, signed, notarized, and returned to the Fund Office in order to opt out of Fund coverage.

NOTE: As a Member, if you opt out of Fund coverage, you will lose all Fund benefits, and all of your eligible dependents (your spouse and any of your children under the age of 26) will automatically lose all Fund benefits as well.

Member Information

All fields are required. Please Print.

Last Name	**First Name**	**Email**	**Date of Birth**
Street Address	**City**	**State/Zip**	**Phone Number**

Declining Coverage - Additional Coverage

Do you, or any of your dependents covered, also have coverage through another medical insurance plan? Remember, Medicaid nor Medicare are not acceptable alternative coverage. (Please check one)

☐ YES
☐ NO

If YES, please complete the information in the chart below for <u>each covered individual,</u> including yourself, who is enrolled in the plan:

Subscriber Name	Insurance Carrier	Group Number	Member Policy Number	Relationship to Employee

If declining coverage, please return this form AND a copy of your current acceptable alternate coverage to the address at the bottom of this page.

Declining Coverage - Signatures

Please check one of the following reasons for <u>declining</u> coverage:

- ☐ I have alternate coverage from other employment.
- ☐ I have alternate coverage as a spouse, domestic partner, or dependent.
- ☐ I have alternate coverage from prior employment or military service.
- ☐ I have alternate coverage through an individual policy.

Waiver Statement

*I acknowledge that I have been offered the opportunity to enroll in, or continue to have, health and other related coverage through the Fund for myself and my eligible dependent(s). I am **declining** coverage with the Fund on my own behalf and on behalf of my spouse and any of our children under age 26 (if applicable), due to the fact that I am currently covered through my spouse's employer group health plan, the details of which are listed above.*

I acknowledge that by making this opt out election and declining coverage with the Fund, myself and my dependent(s) listed above, will not be entitled to any Fund benefits, including hospital, medical, prescription drug, dental and vision. I also acknowledge that even if I opt out of Fund coverage, my Contributing Employer(s) will still be legally required to contribute the amount stated in the Collective Bargaining Agreement to the Fund for my work in Covered Employment, and that <u>I will not</u> receive additional monies in my paycheck in connection with this opt-out election. I understand that I will only have the

opportunity to re-enroll in the Fund if I am eligible for Fund coverage at the relevant time and I am electing to re-enroll during the Fund's annual open enrollment period or I have a qualifying life event that results in a "special enrollment right."

I further acknowledge that this opt out election will take effect as soon as administratively practible, which will normally be the 1st day of the month following the month in which this properly completed election form is received by the Fund's administrative office or, in instances where such a form is received late in a month, the first day of the next immediately following the month.

Finally, I acknowledge to the Fund that the information provided in this document is true and correct, and that I am signing this document under penalties of perjury.

Employee Signature	**Date**

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ACKNOWLEDGMENT

STATE OF CONNECTICUT)
) ss. _____ _____, 20_____
COUNTY OF _____)

Before me, _____ (*insert notary / Commissioner name*), the undersigned officer, personally appeared _____ (*insert Member name*), known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and swore that he or she executed the same, as his or her free act and deed, for the purposes therein contained.

_____
Name: _____
Commissioner of the Superior Court
Notary Public
My Commission Expires: _____

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Mail Completed Form To:
Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, NY 10001

OR Email Completed Form To:
Eligibility.dept@dhcook.com

OR Fax Completed Form To:
(646) – 381 – 8821

Questions? You can call our Customer Service Department at (212) 505-5050, option 3

DANIEL H. COOK
ASSOCIATES INC

Dependent Opt-out Form

Group Name: Sheet Metal Worker's Local No. 40 Health Fund

Please use this form if you wish to opt out of your Sheet Metal Workers' Local No. 40 Health Fund ("Fund") as an eligible dependent (spouse or child) of a covered Member. This form must be filled out, signed, notarized, and returned to the Fund Office in order to opt out of Fund coverage.

NOTE: As a Dependent, if you opt out of Fund coverage, you will lose all Fund benefits.

Dependent Information

All fields are required. Please Print.

Last Name	First Name	Email	Date of Birth
Street Address	**City**	**State/Zip**	**Phone Number**

Declining Coverage - Additional Coverage

Do you have coverage through another medical insurance plan? (Please check one)

☐ YES
☐ NO

If YES, please complete the information in the chart below for <u>each covered individual,</u> including yourself, who is enrolled in your alternative plan:

IF YOU ARE A SPOUSE ELECTING TO OPT OUT FOR YOUSELF AND ANY MINOR CHILDREN, PLEASE LIST THE NAMES OF ANY MINOR DEPENDENT CHILDREN FOR WHOM YOU ARE ALSO MAKING AN OPT OUT ELECTION.

Subscriber Name	Insurance Carrier	Group Number	Member Policy Number	Relationship to Employee

If declining coverage, please return this form AND a copy of your current acceptable alternate coverage to the address at the bottom of this page.

Declining Coverage - Signatures

Please check one of the following reasons for <u>declining</u> coverage:

☐ I have alternate coverage from other employment.
☐ I have alternate coverage as a spouse, domestic partner, or dependent.
☐ I have alternate coverage from prior employment or military service.
☐ I have alternate coverage through an individual policy.

Waiver Statement

*I acknowledge that I have been provided with health and other related coverage through the Fund as an eligible dependent. I am **declining** coverage with the Fund on my own behalf (and if a spouse on behalf of any minor children listed above - if applicable), due to the fact that I am currently covered through my own (for a spouse or an adult child under age 26), or my other parent's (for minor child), employer group health plan, the details of which are listed above.*

I acknowledge that by making this opt out election and declining coverage with the Fund, I and any minor children in the case of a spouse, listed above, will not be entitled to any Fund benefits, including hospital, medical, prescription drug, dental and

vision. I understand that I will only have the opportunity to re-enroll in the Fund if I am eligible for Fund coverage at the relevant time as an eligible dependent of a covered Member and I am electing to re-enroll during the Fund's annual open enrollment period or I have a qualifying life event that results in a "special enrollment right."

I further acknowledge that this opt out election will take effect as soon as administratively practicable, which will normally be the 1st day of the month following the month in which this properly completed election form is received by the Fund's administrative office or, in instances where such a form is received late in a month, the first day of the next immediately following the month.

Finally, I acknowledge to the Fund that the information provided in this document is true and correct, and that I am signing this document under penalties of perjury.

Dependent Signature	**Date**

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ACKNOWLEDGMENT

STATE OF CONNECTICUT)
) ss. _____ _____, 20_____
COUNTY OF _____)

Before me, _____ (*insert notary / Commissioner name*), the undersigned officer, personally appeared _____ (*insert Member name*), known to me (or satisfactorily proven) to be the person whose name is subscribed to the within instrument and swore that he or she executed the same, as his or her free act and deed, for the purposes therein contained.

_____
Name: _____
Commissioner of the Superior Court
Notary Public
My Commission Expires: _____

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Mail Completed Form To:
Daniel H. Cook Associates, Inc.
253 West 35th Street, 12th Floor
New York, NY 10001

OR Email Completed Form To:
Eligibility.dept@dhcook.com

OR Fax Completed Form To:
(646) – 381 – 8821

Questions? You can call our Customer Service Department at (212) 505-5050, option 3