CENTRAL PA TEAMSTERS HEALTH & WELFARE FUND
PLAN 14

Waiver of Medical Coverage Form

Member Name _____ Spouse's Name _____
SS# _____ SS# _____
Address _____ Address_____
_____ _____

Please **list yourself and all dependents eligible for coverage** and note whether they will be covered under the CPAT Plan or waive coverage-

Name	DOB	Dependent Status	Covered//Waived	Ins. Co Name & Policy No. [If waiving coverage]
		(Self)		

(Additional dependents may be added on the reverse side)

By signing below, I (and my spouse, if applicable) hereby elect, effective _____, to waive any and all medical benefits that are or may be provided to me (and my spouse and dependents, if applicable) under the Central Pennsylvania Teamsters Health & Welfare Fund in order to avoid duplication of medical coverage otherwise available to me/us. I/We elect to waive such medical coverage under the Welfare Fund for the following reasons:

_____

I/We understand that the Fund will provide no other benefit, economic or otherwise, in connection with my/our waiver of medical coverage.

I/We further understand that, upon a written request by me (or my spouse, if applicable), medical coverage under the Welfare Fund will be reinstated for me (and my spouse and dependents, if applicable) pursuant to the "Special Enrollment Rules" set forth in the Plan and which are attached or during the next "Open Enrollment" period, provided I otherwise satisfy all eligibility requirements for coverage under the Welfare Fund in effect at that time.

_____
Participants Signature

_____
Spouse Signature (required)

_____
Date

Central Pennsylvania Teamsters Health & Welfare Fund
Plan 14 Special Enrollment Rules

You can enroll yourself and your dependents outside the Annual Open Enrollment Period if you and your dependents are “special enrollees” – that is, individuals entitled to enroll in coverage without waiting until the Fund’s next Open Enrollment Period.

A participant or dependent may be considered a “special enrollee” if he has previously declined coverage under the Fund and if he has lost other health benefits coverage. If the other coverage was COBRA continuation coverage, special enrollment can be requested only after the COBRA continuation coverage is exhausted. In addition, a new dependent may be a “special enrollee” if he has newly become eligible for benefits under the Fund's rules, through marriage, birth, adoption or placement for adoption.

NOTE: individuals must notify the Fund of their request for special enrollment within 30 days after losing their other coverage or within 30 days of having (or becoming) a new dependent. If the participant or dependent can be deemed a “special enrollee,” coverage will be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received.

> ***Caution: A “special enrollee” is subject to the same pre-existing condition exclusion rules as an individual who has initially become eligible for benefits. However, a newborn, adopted child or child placed for adoption cannot be subject to a preexisting condition exclusion period if the child is enrolled within 30 days of birth, adoption or placement for adoption and has no subsequent significant break in coverage. A twelve (12) month exclusion period, reduced by Creditable Coverage, applies.***