TEAMSTERS MISCELLANEOUS SECURITY TRUST FUND

Request to Opt-Out of Coverage under the Plan as an Active Employee
Please submit proof of current Other Group Health Coverage with your request
(ID Cards are not acceptable proof of coverage)

1. Employee's Name:_____
   SS#:_____
   Employer:_____

2. Which individuals are covered by the request?
   Employee's Name:_____

   Spouse's Name:_____

   Domestic Partner's Name (if applicable):_____

   Dependent Children (Name(s) and Date(s) of Birth):_____

   _____

3. Date you wish to opt-out of health and welfare coverage (must be at the beginning of the month):_____
   _____

4. Type of Suspension or Postponement:

   ☐ Have other employment-related group health and welfare coverage – complete question 5.

   To postpone or suspend coverage each individual must be covered under the other group health plan. Also, your spouse, domestic partner, and children cannot continue to participate in the Plan if only you, as the Employee, postpone or suspend coverage for such benefits.

   ☐ Opt-Out of Coverage Because Both You and Your Spouse (or Your Domestic Partner, if applicable) Work for Contributing Employers to the Plan and are Both Covered by said Plan – complete question 6.

5. Information about other employment-related group health care coverage:
   a. Name of Employer:_____
   b. Type of Plan/Group #:_____
   c. Effective Date of Other Coverage:_____
   d. Who is covered under other insurance (You/Spouse or Domestic Partner/Dependent Children):

   _____

   _____

   e. Plan Administrator Name/Insurance Name, Address, Phone Number (if applicable):

   _____

   _____

6. Information about Contributing Employers to this Plan:
   a. Name of Employer:_____
   b. Address of Employer:_____
   c. Name of Employer:_____
   d. Address of Employer:_____
   e. Who do you want to be covered as an Active Employee under the Plan (You –or– Spouse – or Domestic Partner, if applicable):_____
   f. State Relationship Status between Employee and Individual Selected in item 6.e.: (e.g., Self, Spouse or Domestic Partner)_____
   g. Who do you want to be covered as the Dependent under the Plan (You –or Spouse – or Domestic Partner, if applicable):_____
   h. State Relationship Status between Employee and Individual Selected in item 6.g.: (e.g., Self, Spouse or Domestic partner)_____
   i. Who are the other Dependents who you want to be enrolled under the Plan?

_____

The employment-related group health coverage for any individual that postpones or suspends Plan coverage must be continuous. Once you opt-out of your coverage under this Plan, you must remain in that other group health coverage for a minimum of one year, except if your eligibility under that other group health coverage terminates. Once your coverage has been suspended for a minimum of one year, you will be allowed to opt back in provided proof of continuous coverage is provided. While your Plan coverage is suspended, you must annually complete and submit a Plan attestation form and documentation deemed acceptable to the Plan that you are maintaining other continuous group health coverage. If you fail to do so before your opt out anniversary, the Plan will require your employer to pay the full contribution (e.g. for medical, prescription drug, dental, vision, mental health/substance abuse benefits or life insurance benefits, if applicable) effective with the first of the month after your opt out anniversary date.

Any interruption of that coverage for any reason will be deemed a termination of coverage. If that happens, you must notify the Administrative Office no later than 60 days following the termination of your other group health coverage. If timely notice is not given, your option to return to the Plan will be available on a prospective basis only. The Administrative Office will notify you in writing of what enrollment forms and paperwork that you must complete to enroll or re-enroll in the Plan coverage and the due date.

I hereby certify, the above information is true and I have read the Plan provisions governing "Opt-Out Rules" under the Active Plan that are attached.

_____
Signature of Employee Date

_____
Print Name

_____
Signature of Spouse/Domestic Partner/Parent Date
Circle one: Spouse or Domestic Partner

_____
Print Name

Please remit completed form to:

Northwest Administrators, Inc.
225 South Lake Avenue, Suite 1200
Pasadena, CA 91101