IBEW Local 269 Welfare Fund Retiree

Opt-Out Application for Retirees:

Medicare Part D Prescription Drug Plan Coverage

This form is to be completed by each individual covered by the IBEW Local 269 Welfare Fund.

I,_____request to **opt-out** of (check below):
Applicant First & Last Name

☐ Medicare Part D Prescription Plan Coverage

Applicant Relationship to the Plan:

☐ Retiree – Date of Retirement_____/_____/_____ **Status (select one):** ○ Married ○ Widowed ○ Single

☐ Spouse of a Retiree – Are You Actively Working?_____If no, Date of Retirement____/____/_____

Social Security #_____-_____-_____ Date of Birth_____/_____/ _____

Waiver to be effective the first day of the month of_____, 20 ___

Other Prescription Drug Insurance Plan Name:_____Eff. Date:_____/_____/____

A copy of all other insurance ID cards must be included with this form for both retiree and spouse (if applicable).

By signing below, I acknowledge that I:

- Am eligible for Medicare Part D Prescription coverage and voluntarily elect to opt-out of the coverage I have selected above.
- Am retired under the IBEW Local 269 Pension Fund.
- Have a one-time election to re-enroll into the Welfare Fund benefits, prior to September 30th, with coverage becoming effective on the immediately following January 1st.

_____ _____
Applicant Signature Date