ALASKA ELECTRICAL HEALTH & WELFARE PLAN

701 E. Tudor, Suite 200
Anchorage, AK 99503
(907) 276-99503
Toll Free: (800) 478-1246

ADULT DEPENDENT ELECTION TO OPT OUT OF PLAN

Please complete the following information (type or print).

Dependent's Name:	**Street Address:**
SSN:	**City:**
Email Address:	**State:**
Date of Birth:	**Zip Code:**
Name of Participant through whom you have coverage and your relationship to them:	

Pursuant to the terms of the Alaska Electrical Health and Welfare Plan I hereby elect to opt-out of coverage provided by the Plan.

I understand that my election will be effective for all claims incurred after the end of the month in which the opt-out notice is received by the Administrative Office. The opt-out will apply to all coverage, including medical, prescription drug, dental, and vision.

I understand that this election by me is not a COBRA qualifying event and that I will not be eligible for COBRA Continuation Coverage from the Plan. Additionally, I understand that if the Participant leaves the Plan or experiences a COBRA qualifying event after I opt-out of Plan coverage, I will not thereafter be eligible to re-enroll in the Plan or to elect COBRA Continuation Coverage from the Plan.

I understand that I will remain eligible to enroll again, provided the Participant is eligible for coverage during the month for which re-enrollment is sought. The re-enrollment will be effective the first day of the month following the month in which the enrollment request is received by the Administration Office.

I certify that the information provided is true and accurate and that I am taking this action voluntarily and on my own initiative.

Signature of Dependent:_____ Date: _____

To be Completed by the Administrative Office

Dependent's Age: _____

Participant is still active in Plan ❑ *YES* ❑ *NO*

The Dependent's opt-out request is: ❑ *APPROVED* ❑ *NOT APPROVED*

*Health & Welfare Supervisor:*_____ *Date:* _____