Alaska Electrical Health & Welfare Fund
701 E Tudor, Suite 200
Anchorage, AK 99503
(907) 276-1246 • (800) 478-1246 • FAX (907) 278-7576
www.aetf.com

REVOCATION OF RETIREE COVERAGE FORM

RETIREE IDENTIFICATION

First Name _____ Initial _____ Last Name _____ SSN _____

Mailing Address _____ City _____ State AK Zip Code _____

Date of Birth _____ Sex _____ Phone Number _____ Marital Status (M/S/D) _____ Date of Marriage _____

SPOUSE IDENTIFICATION

First Name _____ Initial _____ Last Name _____

IMPORTANT NOTICE

If your retiree eligibility was based on 60 months of health and welfare eligibility with this Fund (or 10,400 hours of contributions reported to this Fund) in the 84 months immediately preceding retirement, you may not regain retiree welfare coverage under the Fund unless you have re-satisfied the retiree eligibility rules. You may only regain retiree coverage at age 58 or upon Medicare eligibility, provided you have had:

- 60 months of eligibility for which retiree funding has been paid or
- 10,400 hours of contributions reported to this Fund

in the 84 months preceding attainment of age 58 or upon Medicare eligibility.

If your retiree eligibility was based upon 25,000 hours of contributions reported to this Fund prior to retirement, you may resume retiree coverage at age 58 or upon Medicare eligibility.

REVOCATION

Please terminate the Retiree Health and Welfare coverage for myself and my dependents.
(Please note: This requested change will be effective the first of the month following receipt of this written request by the Administrative Office.)

Retiree Signature _____ Date _____ Spouse Signature _____ Date _____

OFFICE USE ONLY: PLAN NUMBER: _____ TERMINATED EFFECTIVE: _____ INITIALS: _____