I.B.E.W. LOCAL 25 HEALTH & BENEFIT FUND
WAIVER OF BENEFITS FORM

Date: _____

I, _____, Social Security No. _____, residing

at _____,

after having been informed of my rights to participate in the IBEW Local 25 Health and Benefit Fund and, after due consideration, hereby voluntarily waive my participation in the aforesaid Fund for hospital, death, medical, dental, prescription, vision and any other Fund benefits, and I release said Fund from any responsibility or liability to me.

Furthermore, I understand that I will not be able to join the IBEW Local 25 Health and Benefit Fund at a later date unless I experience a "Qualifying Life Event" (see below) that would allow me the opportunity to re-enroll.

A Qualifying Life Event, as defined by federal regulation, is any of the following:

- Loss of eligibility under other coverage;
- Loss of eligibility under Medicaid/CHIP;
- Birth of a child with your participant spouse;
- Adoption, or placement for adoption, of a child with your participant spouse;
- Gain of eligibility for Medicaid/CHIP premium assistance.

I also hereby acknowledge that I am currently enrolled in another medical plan which has been verified as a plan that satisfies the requirements for benefit coverage under the Patient Protection and Affordable Care Act.

_____ _____

Waiving Dependent Signature Notary Public

_____

Participant Signature

_____

Participant Social Security Number

Kindly sign and return this waiver form as soon as possible to the Fund. Termination of coverage will be effective the first day of the month following the date the signed, notarized form is received by the Fund Office.