SEIU Local 105 Health & Welfare Fund

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Administered by
Welfare & Pension Administration Service, Inc.

Health Insurance Opt-Out Form

I am electing to **Opt-Out** of health coverage for myself and my eligible dependents in the SEIU Local 105 Health and Welfare Fund because I have other health coverage through:

Name of Subscriber with Other Coverage | Social Security Number | Policy or ID Number

Name and Address of Other Insurance | City | State | Zip Code

Other Insurance Covers: ☐ Subscriber ☐ Spouse ☐ Children

I understand that by declining health coverage I will not be eligible to enroll myself and/or my eligible dependents in the health plan until the next annual open enrollment period, except in limited circumstances such as if I lose my other coverage.

In order for this declination of coverage to be valid, you must complete this form in its entirety and sign below.

Please Print:

Employee Name | Social Security Number

Street Address or PO Box | City | State | Zip Code

Name of Employer | Building Location

Employee Signature | Date

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