New York State Teamsters Council
Health and Hospital Fund

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MEMBER'S SPOUSE OR DEPENDENT CHILD OPT OUT AUTHORIZATION FORM

TO OPT-OUT YOU MUST COMPLETE THIS FORM

My employer, as a participating employer in the New York State Teamsters Council Health and Hospital Fund, has afforded me the opportunity to enroll my eligible spouse and/or dependent(s) for the benefits offered by the Fund.

By my signature below, I acknowledge that I have been offered the opportunity to enroll my spouse and/or dependents in the benefit programs of the Fund, but have **voluntarily declined to enroll my spouse and/or dependent(s) in the Fund's programs.**

I certify that my spouse and/or dependent(s) are currently covered either as:

- Spouse has primary coverage under his or her own insurance plan;
- dependent(s) under my spouse's health plan or;
- through an individual health policy or;
- through a retiree health plan provided by a previous employer.

I further understand and acknowledge by my signature below that I **may not enroll** my spouse and/or dependent(s) in the Fund's programs in the future.

The only qualifying event exceptions are:

- if my spouse and/or dependent loses benefits and coverage due to job loss or;
- if my spouse and/or dependent's employer discontinues offering health benefits to all employees.
- if dependent children who are covered under a governmental plan loses coverage through no fault of their own. (Age Limitations)

Should any of these situations occur it is understood that I may enroll my eligible spouse and/or dependents for benefits. The benefits provided by the Fund will become effective the 1st of the month following the termination of benefits. Proof of the qualifying event and termination date will be required.

DEPENDENT OPTING OUT (*1 form for each dependent)*

Dependent Opting Out:	Dependent's Social Security #
☐ Spouse ☐ Dependent Child	- -

Name of Spouse/Dependent Child:	Date of Birth:
	/ /

Current Coverage Spouse/Dependent Enrolled In:

Name of Policy Holder:	
Carrier Name:	
Policy Number:	
Effective Date of Coverage:	/ /

NYS Teamsters MEMBER Information:

Member's Name: (Last, First, Middle Initial)	Social Security #
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Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent act, which is a crime and shall be subject to a civil penalty.

Member's Signature:	***Date:***
	/ /

*****MUST RETURN FORM WITH A COPY OF INSURANCE ID CARDS THE EMPLOYEE IS ENROLLED IN*****