MICHIGAN ELECTRICAL EMPLOYEES' HEALTH PLAN

RETIREE/DEPENDENT COVERAGE OPT-OUT FORM

Retiree's Name _____ Retiree's SS# _____

Spouse's Name _____ Spouse's SS# _____

Name/SS# of Retiree's Other Covered Dependents (If Any)

_____

Address _____

Is This a Change of Address? Yes ☐ No ☐

Medicare Number (if opting out of Medicare Advantage Plan) _____

To opt out of plan coverage, complete and return this form.

☐ I, the undersigned Retiree, being eligible to enroll or continue enrollment in Early and Disabled Retiree (E&D Retiree) and Special Fund or Medicare Advantage benefits of the Michigan Electrical Employees' Health Plan (Plan) hereby elect to waive (opt-out) participation in the Plan for [check all that apply]

Myself ☐ My Spouse ☐ Dependent(s) listed above ☐

Election to opt-out of Plan coverage is effective _____, 20 ____

☐ I, the undersigned Dependent spouse of the Retiree above, being eligible for Dependent benefits under the Early and Disabled Retiree (E&D Retiree) and Special Fund or Medicare Advantage benefits of the Michigan Electrical Employees' Health Plan (Plan) hereby elect to waive (opt-out) participation in the Plan for myself.

This election to opt-out of Plan coverage is effective _____, 20 ____

Retiree/Dependent(s) acknowledge receipt of a copy of the Plan's Early and Disabled Retiree (E&D Retiree) and Special Fund or Medicare Advantage benefits of the Michigan Electrical Employees' Health Plan (Plan) plan of benefits. This opt-out election is available on a one-time only basis.

Retiree/Dependent(s) acknowledge that reinstatement is permitted to re-enroll in the Early and Disabled Retiree (E&D Retiree) and Special Fund or Medicare Advantage benefits of the Michigan Electrical Employees' Health Plan (Plan) later **provided that** the Plan is provided with evidence of continuous, uninterrupted **group** health plan coverage on a form satisfactory to the Plan and its Trustees.

Retiree/Dependent(s) [if applicable], hereby acknowledges having read this statement and having considered its contents and the consequences thereof, agree to sign this form of my/our own free will without coercion of any form.

Managed for the Trustees by: Wilson-McShane Corporation
3001 Metro Drive, Suite 500 • Bloomington, MN 55425
(855) 633-4584 • FAX (952) 854-1632
www.michiganelectrical.org

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RETIREE/DEPENDENT COVERAGE OPT-OUT FORM

Signed this _____ day _____, 20 _____

	Printed Name	Signature	Date
Retiree			
Notary			

- OR -

	Printed Name	Signature	Date
Dependent Spouse			
Notary			

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