

**Operating Engineers Local #49 Health & Welfare Fund
Opt-Out For High Deductible Health Plan with HSA Coverage
Waiver of Coverage Form**

Participant Name (Employee/ Retiree)		Date of Birth	
Dependent Name		Relationship to Participant	

A Dependent of an Eligible Employee or Eligible Retiree may elect to opt-out of coverage under this Plan if they are eligible for a health plan offered by their employer that is a high deductible health plan with a Health Savings Account (“HSA”). The Dependent AND Eligible Employee or Eligible Retiree must complete this “Waiver of Coverage” form to opt-out of coverage under the Plan.

The undersigned hereby acknowledge and agree that by electing to opt-out of coverage under the Plan, the Dependent will:

1. Not be entitled to any benefits or other payments from the Plan, including, but not limited to, health care benefits, dental benefits, extended coverage options under federal law, or retiree benefits;
2. Have no right or claim to any contributions made to the Plan for the purposes of funding the Dependent’s eligibility for coverage;
3. Forfeit any right to benefits under the Plan even if Plan benefits are superior in some respects to the benefits under the plan offered by the Dependent’s employer; and
4. Have no right to return to coverage under the Plan until such time as:
 - a. The Dependent’s employer ceases to make the HSA and high-deductible health plan available to its employees or the Dependent loses his or her coverage due to retirement, termination of employment, reduction in work hours, or by becoming eligible for Medicare, and
 - b. The Dependent otherwise meets the eligibility requirements of the Plan, and
 - c. The Dependent provides written notice to the Trustees of the desire to once again become covered by the Plan and submits documentation of the loss of the HSA and high-deductible health plan coverage.

The undersigned hereby acknowledge, agree, and represent that all of the following are true:

1. The Dependent is eligible for a health plan offered by their employer that is a high deductible health plan with a Health Savings Account.
2. The Dependent is otherwise eligible for coverage from the Operating Engineers Local #49 Health & Welfare Fund.
3. Effective _____ (Date), the Dependent elects to opt-out of coverage through the Operating Engineers Local #49 Health & Welfare Fund.
4. Upon signing this form, the Dependent will not be eligible for coverage for claims incurred on and after the effective date of the opt-out of coverage.

Participant	Signature	Date
Spouse or Adult Dependent Waiving Coverage	Signature	Date