



Service. Security. Stability.

# CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

12 E. ERIE STREET, CHICAGO, ILLINOIS 60611 PHONE (312)787-9455, OPTION #4

## RETIREE HEALTH BENEFITS CANCELLATION FORM – DEPENDENT

The cancellation form must be **received** by the Chicago Regional Council of Carpenters Pension Department by the fifteenth (15<sup>th</sup>) day of the month **prior to** the month that you wish to cancel coverage.

Participant's Name (PLEASE PRINT): \_\_\_\_\_

Participant's UID# or SS#: \_\_\_\_\_

### CHECK THE APPROPRIATE CIRCLE(S)

**Dependent Name:** \_\_\_\_\_

- I elect to CANCEL the hospital and/or medical coverage for the above listed Dependent. I understand that this coverage can only be reinstated at a later date if the dependent is covered by continuous hospital/medical coverage (from another employer) from the date of this cancellation to the date of reinstatement.
- I elect to CANCEL the prescription drug coverage for the above listed Dependent. I understand that this coverage can only be reinstated at a later date if the dependent is covered by continuous prescription drug coverage (from another employer) from the date of this cancellation to the date of reinstatement.

**Participant's Signature:** \_\_\_\_\_

**Date Signed by Participant:** \_\_\_\_\_