



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 – PARTICIPANT OR SPOUSE

The cancellation form must be **received** by the Chicago Regional Council of Carpenters Pension Department by the fifteenth (15th) 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)

- I elect to CANCEL MY (the carpenter's) hospital and/or medical coverage. I understand that, if I have a spouse and/or other dependents covered under the hospital and/or medical coverage, this coverage will *also be cancelled for them*. I also understand that this coverage can NOT be reinstated at a later date.
- I elect to CANCEL MY (the carpenter's) prescription drug coverage. I understand that, if I have a spouse and/or other dependents covered under the prescription drug coverage, this coverage will *also be cancelled for them*. I also understand that this coverage can NOT be reinstated at a later date.

Spouse's Name _____

- I elect to CANCEL the hospital and/or medical coverage for MY SPOUSE. I understand that this coverage can only be reinstated at a later date if my spouse furnishes proof of continuous hospital/medical coverage (from his/her employer) from the date of this cancellation to the date of reinstatement.
- I elect to CANCEL the prescription drug coverage for MY SPOUSE. I understand that this coverage can only be reinstated at a later date if my spouse furnishes proof of continuous prescription drug coverage (from his/her employer) from the date of this cancellation to the date of reinstatement.

Participant's Signature: _____

Date Signed by Participant: _____