

**ELECTION TO WAIVE HEALTH INSURANCE COVERAGE
AND HOLD HARMLESS AGREEMENT**

Front and back must be completed

Participant Information:

Last Name _____ First Name _____

Social Security # _____ Date of Birth _____

Street Address _____

City _____ State _____ Zip Code _____

Marital Status: Single _____ Married _____ Widowed _____ Divorced _____

I hereby elect not to have health insurance premiums withdrawn from my personal account. I understand that by making this Election my health coverage under the IBEW Local 236 Health and Benefit Fund (the "Fund") will terminate on the first day of the month following the month in which I file this Election and supporting information with the Fund Office and the Trustees of the Fund approve this Election. I was given the opportunity to enroll in the IBEW Local 236 Health & Benefit Fund's Group Health Benefits. I waive the following: (choose one only)

_____ Coverage for Employee, Spouse and Children Medical _____ Dental _____

_____ Coverage for spouse only Medical _____ Dental _____

_____ Coverage for children only Medical _____ Dental _____

I also understand that I can only make this Election if I am covered under my spouse's employer's health care plan, or some other employer health care plan, that has hospitalization and other comprehensive medical coverage, (referred to as "Substitute Coverage"). Further, if such Substitute Coverage stops (except for COBRA), the Plan's Insurance Benefit health care insurance must be started, from my account, effective no later than the first day of the month after 90 days from the date the other coverage stops (except for COBRA). I am waiving the IBEW Local 236 Health & Benefit Fund's Group Health Benefits for the above and I hereby certify that I have Substitute Coverage through (check one):

____ my spouse's or ____ another employer's health insurance:

Name of Employer: _____

Name of _____

Insurance Carrier: _____

and Address: _____

Insurance Policy Number: _____ Effective Date of Insurance: _____

Insurance coverage includes: Medical _____ Dental _____ Vision _____

I understand that if I later wish to enroll for any coverage(s) waived, I can do so only during Open Enrollment or upon my spouse's loss of coverage under his/her employer's Health Insurance or my loss another employer's health insurance. I further understand that I must complete the proper enrollment forms at such time.

(over →)

I further acknowledge that my Substitute Coverage may not provide benefits for me or my eligible dependents that are equivalent to my health coverage under the Fund, and that the Fund has made no determination on my behalf as to the equivalency of benefits under my Substitute Coverage in connection with this Election.

I have attached the following copies as "Proof of Current Coverage":

- Employer/Insurer Letter certifying that spouse is covered and member is eligible for coverage.
- Insurance card – listing participant & family
- Certificate of Insurance for Summary Plan Description or Insurance Booklet
- Other (Describe): _____

In consideration of my being allowed to make this Election, I hereby agree, for myself and my eligible dependents, to indemnify the Fund, the Trustees of the Fund and their employees, agents and representatives, and hold them harmless, against any damages, costs or expenses, which they may suffer or incur, including reasonable attorneys' fees, arising out of any actions, causes of action or claims for or relating to benefits to which I or any of my eligible dependents would have been entitled had I not made this Election. This Agreement shall be binding upon my heirs, executors, administrators and assigns, and shall inure to the benefit of the Fund, its Trustees, employees, agents and representatives, and their successors and assigns.

Member's Signature: _____

Print Name: _____ Date: ____/____/2009

Spousal Signature & Acknowledgement (must be present where applicable):

I certify that I am the spouse of _____ and I hereby consent to the foregoing Election and Hold Harmless Agreement.

Spouse's Signature: _____

Print Name: _____ Date: ____/____/2009

STATE OF NEW YORK)
COUNTY OF)ss:

On the ____ day of _____ in the year 20__ before me, the undersigned, personally appeared _____, personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name are/is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her/their capacity(ies), and that by his/her signature on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Notary Public - State of New York