Retiree Medical Coverage
Election Form for Dependent Children

Electing/Declining Dependent Coverage: (Please select ONE)

I, ___________________________________,ELECT as of: ______________________
to have the IBEW Local 701 Health and Welfare Coverage for my dependent child(ren), listed below, who is/are under the age of 26. I am also authorizing the Pension Fund to deduct the appropriate dollar amount for this coverage from my pension check.

I, ___________________________________, DECLINE or wish to DROP the IBEW Local 701 Health and Welfare Coverage for my dependent child(ren), listed below
As of: ______________________________

NOTE: DEPENDENT MEDICAL BENEFITS WILL END ON THE DAY HE/SHE NO LONGER MEETS THE DEFINITION OF ELIGIBLE DEPENDENT. SEE WELFARE SUMMARY PLAN DESCRIPTION FOR THE DEFINITION OF AN ELIGIBLE DEPENDENT.

_____________________________________ ________________________
Signature Date

Dependents you would like to cover under the age of 26
** Fill out *'Special Enrollment Form'* for each dependent if he/she is over age 19

1.) ___________________________ SSN: _______________ DOB: ____/___/____

2.) ___________________________ SSN: _______________ DOB: ____/___/____

3.) ___________________________ SSN: _______________ DOB: ____/___/____

4.) ___________________________ SSN: _______________ DOB: ____/___/____

5.) ___________________________ SSN: _______________ DOB: ____/___/____