Bricklayers Fringe Benefit Funds

BAC Local Union No. 1, NY
66-05 Woodhaven Boulevard, Rego Park, New York 11374 (718) 459-5800
Anthony LaCava, Jr.
Administrator

Dis-enrollment Form Due to Medicare/Medicaid-Entitlement

Member Information:

Last Name		First Name		Middle Initial (MI)
Mailing Address			Social Security #	
City		State	Zip code	
Gender: ☐ F ☐ M	Date of Birth (Month/Day/Year)	Daytime Phone Number ( )	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced	

I wish to dis-enroll (drop/reject coverage for) the following individual from the Plan due to the individual's entitlement to Medicare/Medicaid. Please note that in order for this request to be processed, <u>you must sign this form and provide a copy of the individual's Medicare/Medicaid ID card</u>. The change will be effective the first of the month following the month in which this completed and signed form is received by the Fund Office.

Disenrollment: Complete this section for the person who wants to drop (reject) coverage due to Medicare/Medicaid-entitlement (individual must be eligible for and enrolled in Medicare Parts A and B or other government sponsored medical coverage carrier).

Relationship to Member	Last Name, First Name and Middle Initial	Sex	DOB	SS#	Date Individual was Initially Eligible for Medicare	DROP coverage
						☐DROP ☐DROP
						☐DROP
						☐DROP
						☐DROP
						☐DROP

*****COMPLETE AND SIGN THIS SECTION *****

I understand that the individual list above is currently enrolled for health care coverage but I am dis-enrolling (waiving or rejecting) coverage for this individual due to Medicare/Medicaid-entitlement.

- I understand that I am rejecting/waiving coverage for the individual listed above.
- I understand that I will receive no additional compensation for waiving this coverage.
- I understand that I am waiving all coverage under this Plan for the above individual and he/she will not be eligible to receive any benefits under the Plan once this request is processed. Any claims that are received after the date of disenrollment will be returned unpaid.
- I understand that waiving coverage means that I cannot re-enroll the individual listed above until I request re-enrollment by completing and signing a new enrollment form. Coverage will become effective for the re-enrolled individual on the first of the month following the month in which the Fund Office receives the completed and signed enrollment form. Please note that you may be required to provide certain supporting documents when you request re-enrollment.
- I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. [Misrepresentation of information can result in termination of coverage and/or criminal and/or civil prosecution.]

Signature of Employee____**Date**____________________________

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Waiver of Coverage Employee (or Dependent) Certification

As an employee (or an eligible dependent of an employee) working in covered employment for a contributing employer to the Bricklayers Insurance and Welfare Fund ("Fund"), I understand that I am eligible for health coverage provided under the Fund pursuant to the collective bargaining agreement with such contributing employer and the plan terms and rules governing the Fund. By signing this form, I acknowledge that I am opting out of health and medical coverage under the Fund because I have alternative medical coverage elsewhere. I also certify that the following statements are true:

1. I certify that, under penalty of perjury, I have voluntarily elected to receive medical coverage under another health plan other than the Fund either as a participant or as an eligible dependent.

2. I certify that, under penalty of perjury, my alternative health coverage is affordable and covers essential health benefits offered through a private or public Exchange, purchased from a private insurance company, is employer-sponsored by another employer, and/or provided by a federal, state, or local medical assistance program, such as Medicaid* or Medicare ("Government Program").

3. I certify that, under penalty of perjury, in the case of alternate coverage provided by a Government Program, I have advised such Government Program that I am otherwise eligible for coverage under the Fund but have opted-out of such coverage.

4. I certify that I have voluntarily elected to opt-out of coverage under the Fund.

Name: ____

Date: _______________

Signature: ____

* If you wish to elect or maintain Medicaid coverage and decline health coverage under the Fund, you must first advise Medicaid of the availability of coverage under the Fund. Medicaid will then determine whether eligibility for Fund coverage will prevent you from enrolling in, or maintaining coverage on, Medicaid. Alternatively, Medicaid may decide that, as an alternative to Medicaid coverage, it will help you pay whatever employee co-premiums you must pay for Fund coverage. Please let us know of Medicaid's determination after it reviews your situation.

(OVER)