<u>**Mid Central Operating Engineers Health & Welfare Fund**</u>
PO Box 9605, Terre Haute, IN 47808 812-232-4384

Retiree In-and-Out Program Application

Retiree Information – Complete the following information:

Retiree Name Date of Birth

Social Security Number Phone Number

Address City State Zip Code

Coverage can only be postponed/suspended effective the 1st of the month:

______ I want to postpone/suspend coverage for myself and my dependents, effective _________________

______ I want to postpone/suspend coverage for my dependents only, effective______________________

______ I want to postpone/suspend coverage for my spouse only, effective ________________________

This is a one-time only option; however, you may choose to suspend coverage at any time. To suspend you must complete, sign, and return this application to the Welfare Fund at least 30 days prior to the date you wish your suspension of coverage to be effective. If you elect to suspend coverage, upon approval of your Retiree In-and-Out Program Application by the Welfare Fund, your coverage will be suspended as of the first day of the month following both the timely receipt of your completed application and approval by the Welfare Fund.

Dependent Information: Provide the following information for each eligible dependent for whom coverage will be postponed/suspended.

Spouse's Name Social Security Number Birth Date

Dependent Name Social Security Number Birth Date

Dependent Name Social Security Number Birth Date

Authorization

I/We choose to postpone/suspend coverage under the Mid Central Operating Engineers Health and Welfare Fund retiree program at this time. By signing below, I/We certify that I/We have read and understand the rules regarding postponing/suspending retiree coverage and understand that this is a <u>**one-time election**</u> and that I/We must provide proof of other qualifying coverage for both Medical and Prescription when I/We begin/resume the Plan's retiree coverage. Further, I understand that my Employee Point Total and credit hours will remain the same as when I initially retired. I understand that <u>**no partial refunds are issued due to opting out during any time during a benefit period.**</u>

Member's Signature____Date____________

Spouse's Signature____Date____________

Dependant's Signature____Date____________