WISCONSIN ELECTRICAL EMPLOYEES HEALTH AND WELFARE PLAN
2730 DAIRY DRIVE SUITE 101
MADISON WI 53718
(608) 276-9111 Phone, (608) 276-9103 Fax or fundoffice@weebf.org

RETIREE TERMINATION FORM

I, _____ (print name clearly), ID# _____
do hereby notify the Wisconsin Electrical Employees Health and Welfare Plan (the Fund) that I wish to terminate my Retiree coverage with the Fund. **I understand that any credits in my Dollar Bank and Supplemental Unemployment Account (if applicable) will be automatically transferred into my Flexible Benefit Account (Flex Account), if not already:**

☐ I elect to terminate my coverage under the Fund effective _____.

(must be the beginning of a month).

I understand that to get back into Fund coverage, I must return to work for a Contributing Contractor who submits H&W contributions to the Fund on my behalf, reinstating my active status will be the month following receipt of 150 hours. I understand I will still have access to my Flex Account balance as long as I maintain account activity (refer to #4 below) subject to the Plan's Flex Account forfeiture provisions.

I understand that upon <u>Termination of my Retiree coverage with the Fund</u> that ALL of the following will apply:

1. I understand that all my eligible dependents listed on my policy will be terminated for medical, prescription drug and any optional benefits that were elected as of the termination date above
2. I understand that I will lose my life benefit coverage under the Plan as of the termination date above.
3. I understand I can only file Flex Reimbursement claims on myself and my spouse for any out-of-pocket expenses after All Insurance Carriers has processed their benefits and proof of their benefit payment is required when filing for Flex reimbursement.
4. I understand my Flex Account will be forfeited if there is no account activity (benefits paid from) for five consecutive calendar years OR for accounts holding $400 or less and entire calendar year.
5. I understand that, if applicable, the Local Union #14 Retiree Subsidy is not transferable to any other Insurance and/or Medicare Plan, and I will lose my monthly contribution. Please notify Local Union #14 of your termination of Retiree coverage with the Fund and if you have any additional Subsidy benefit language questions.
6. I understand that, if applicable, if I am covered under the UHC Group Retiree Advantage Plan, that I must also complete their cancellation notice asap and return to UHC in order to cease my coverage through them. If no cancelation form is received, I understand I will be liable for the premium until said cancelation form is received by UHC and terminated based on Medicare rules and regulations.

_____ _____
Retiree Signature Date

_____ _____
Retiree Spouse's Signature Date