



Musicians Health Fund

322 West 48th Street, New York, NY 10036
Phone: 212-245-4802 • Fax: 212-245-2304
E-mail: hbp@local802afm.org

WAIVER OF BENEFIT COVERAGE

I, _____, hereby acknowledge that I have been given the opportunity to participate in the Local 802 Musicians Health Fund (the "Fund"). I have received a documentation which clearly and thoroughly describes the Fund's benefits.

I hereby waive the receipt of such Fund benefit coverage for myself and my eligible family members (if any) effective as of _____, because I (we) have medical coverage from another source.

I further understand that if I wish to enroll myself and my eligible family members (if any) in the Fund in the future (other than during an open enrollment period), I may do so only if: (i) I am eligible for coverage under the Fund at that time (in accordance with the Fund's eligibility rules), and (ii) I have a "special enrollment right" within the meaning of the Health Insurance Portability and Accountability Act (as described in the attached Notice of Special Enrollment Rights), and (iii) I request enrollment in writing within the required 30 day-period, as described in the attached Notice, and provide the Fund with any and all required documentation (such as proof of a loss of other coverage). The Fund and its Trustees retain the right to determine the appropriateness of the documentation submitted as proof of losing other coverage.

I acknowledge that I am familiar with, and fully understand, the terms and conditions of the Fund, and I have waived coverage deliberately, voluntarily and with full knowledge of my waiver's significance.

Date

Employee Signature

Union Card # or Insurance ID#

Print Name

THIS FORM MUST BE NOTARIZED

Subscribed and sworn to before me this

____ Day of _____, 20____

SPECIAL ENROLLMENT RIGHTS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependants in this Fund in the future if you or your dependants lose eligibility for that other coverage (or if the other employer stops contributing towards you or your dependants' other coverage). However, you must request enrollment within 30 days after you or your dependants' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependant as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependants in this Fund. However you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

Note Regarding Effective Date of Coverage: If you enroll in the Fund pursuant to these provisions, your coverage will begin {on the first day of the first calendar month beginning after the date the Fund receives your request for special enrollment}, except in the case of the birth or adoption of a child, in which case coverage will begin on the date of birth, adoption or placement for adoption.

To request special enrollment or obtain more information, contact Gloria McCormick, Administration, Local 802 Musicians Health Fund at (212) 245-4802