Local No. 1 Health Fund
SEIU United for Good Jobs and Strong Communities

Service Employers Local No. 1 SEIU-CLC
Apartment Building Owners and Managers Association
1431 Opus Place, Suite 350
Downers Grove, IL 60515

Phone: (630) 288-6868
Toll Free: (866) 844-0488
Administered by Wilson-McShane Corporation

# Dependent Coverage Waiver

This form should be completed only if you are requesting that a Dependent be ***removed*** from your SEIU Local No. 1 Health Fund coverage.

By signing this form, I am indicating my request to waive coverage under the SEIU Local 1 No. 1 Health Fund (further identified as the "Fund" or "Plan") for the below named Dependent(s) In signing this form, I acknowledge that the Fund will cancel coverage for the below-named Dependent(s) as of the 1st day of the next month after this form has been received by the Fund Office. I understand that on/after January 1, 2026 I may submit a request to drop Dependent coverage mid-year only within 60 days of my Dependent(s) becoming eligible for other coverage (such as Medicaid, Medicare, or another group health plan).

I acknowledge that a voluntary waiver of Plan benefits is not a COBRA qualifying event, and thus the Dependent will not be entitled to COBRA continuation coverage. (This Dependent Coverage Waiver form should be used only to waive coverage for otherwise eligible Dependents; it should not be used to notify the Fund of a COBRA qualifying event such as divorce or a Dependent child exceeding the maximum age for eligibility. If such an event occurs, you must notify the Fund Office no later than 60 days from the date of the event; you may ask the Fund Office for a Notice of Qualifying Event form which may be used for this purpose. If your Dependent loses coverage due to an occurrence of a COBRA qualifying event, the Dependent may be entitled to COBRA continuation coverage.)

I further acknowledge that Plan benefits will only become payable again in the future with respect to the below-named Dependent(s) if Dependent(s) meets the requirements of the eligibility rules as set forth in the Plan document and I I affirmatively re-enroll the Dependent on a form designated by the Fund. Re-enrollment in the Plan can only occur during the Plan's annual open enrollment period (if offered) and generally takes effect as of the first of the next calendar year or within 60 days of the Dependent's loss of other coverage.

Member Name & Date of Birth _____

Member Social Security Number _____

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Dependent's Name _____

Dependent's Date of Birth _____

Other Insurance

Provided By: _____

Effective Date:_____

(Documentation must be provided)

_____ _____

Member Signature Date