UNITED FEDERATION OF TEACHERS WELFARE FUND

DECLINATION OF WELFARE FUND COVERAGE

(DENTAL AND/OR VISION BENEFITS)

Member Name Last_____ First _____ Middle_____

Address _____

Social Security Number _____ Date of Birth _____

This is to acknowledge and certify that I am currently a covered member of the United Federation of Teachers Welfare Fund ("Fund").

However, effective upon my signing of this form, I hereby decline and waive further coverage of the following Fund benefits for myself and any of my eligible dependent(s) currently enrolled in such benefits (please place a "check mark" below next to the benefits you wish to decline):

____ **DENTAL BENEFITS** ____ **VISION BENEFITS**

I understand and acknowledge that if I wish to re-enroll myself and any eligible dependent(s) in the future that I removed from these benefits, because I and said eligible dependent(s) have lost other comparable benefits coverage from another source, I will be permitted to do so, upon submission to the Fund of proof of the loss of the other coverage, within 30 days of the loss of such coverage.

I hereby agree to indemnify and make whole the United Federation of Teachers Welfare Fund, its heirs and assigns against any and all liability and/or loss arising out of my request to decline and waive further coverage of these benefits for myself and any eligible dependents currently enrolled.

Member's Signature _____ Date _____

Sworn to before me this
_____ day of _____, 20__.

_____
Notary Public

20140303