UNITED FEDERATION OF TEACHERS WELFARE FUND

DECLINATION OF WELFARE FUND COVERAGE

(FOR ELIGIBLE DEPENDENTS)

Member Name: Last________________ First _______________ Middle_____________

Address ____

Social Security Number _____-_____-________ Date of Birth ____/______/_____
Or (WF –Alternate ID) ____________________

This is to acknowledge and certify that I am a covered member of the United Federation of Teachers Welfare Fund ("Fund") and that I, and my eligible dependents as defined by the Fund, are currently enrolled in and are receiving Fund benefits.

However, effective upon my signing of this form, I hereby decline and waive further Fund coverage for the following eligible dependent(s) and request that said dependent(s) be removed from Fund coverage immediately.

Print name(s) of eligible dependent(s) for whom member is declining continued coverage below (please include relationship to member e.g. spouse, domestic partner, child, etc.):

________________________	__________________	_______-_____-________
Dependent's Name	Relationship to Member	Social Security Number
________________________	__________________	_______-_____-________
Dependent's Name	Relationship to Member	Social Security Number
________________________	__________________	_______-_____-________
Dependent's Name	Relationship to Member	Social Security Number

I understand and acknowledge that if I wish to re-enroll any eligible dependent(s) in the future that I removed from Fund coverage because said eligible dependent(s) have lost other comparable 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 Fund coverage for my eligible dependents listed herein.

Member's Signature ________________________ Date ____________________

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

____
Notary Public

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