

**UNITED FEDERATION OF TEACHERS WELFARE FUND**

**DECLINATION OF WELFARE FUND COVERAGE**

**(ALL 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 all Fund benefits for myself and any of my eligible dependent(s) currently enrolled in such benefits. I understand and acknowledge that these benefits include the Fund's dental, optical, prescription drug, hearing aid, disability, death, supplemental and health and cancer hotline programs.

I understand and acknowledge that if I wish to re-enroll myself and any eligible dependent(s) in the future that I removed from Fund coverage, 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 Fund for myself and any eligible dependents currently enrolled.

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Sworn to before me this  
\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Notary Public