



District Council 1707, Local 95
Head Start Employees Welfare Fund

ENROLLMENT WAIVER

I, the undersigned, hereby certify that I have been afforded an opportunity to enroll in the Group Health Insurance offered by DC 1707, Local 95 Head Start Employees Welfare Fund and after careful consideration have decided not to enroll and waive my right to such coverage.

I understand that I will not be able to join the Welfare fund and its health insurance plan at a later date unless I experience a qualifying event that would allow me the opportunity to enroll.

Qualifying Life Events

A Qualifying Life Event, as defined by IRS regulations, allows you to make a change to your benefit coverage under a group health plan or health insurance if you experience any of the following:

Change in status, including but not limited to:

- Marriage or divorce
- Death of a dependent
- Birth or adoption of a dependent
- Change in employment status
- Dependent satisfying or ceasing to satisfy plan's eligibility requirements

Loss of coverage due to but not limited to:

- Termination of employment
- Termination of the other plan
- Death of the employee covered by the plan
- Legal separation
- Reduction in the number of hours of employment
- Pursuant to a judgment, decree or court order

Please complete information on reverse side of this form.

I decline enrollment in the DC 1707, Local 95 Head Start Employees Welfare Fund and its health insurance plan because;

Please mark the appropriate reason for waiving coverage

- Covered under another insurance plan Cannot afford cost

Employee Signature

Date

Print Name

Home Address

Head Start Center Name

Telephone Number

To be completed by Head Start Center Director/Bookkeeper

Head Start Center Code # _____

Head Start Center Name _____

Head Start Center Address _____

Above is certified by

Print Name _____ Title _____

Signature _____ Date _____

Please keep copy and mail original form to;

**DC 1707, Local 95 Head Start Employees Welfare Fund
420 West 45th Street, 3rd Floor
New York NY 10036**

Welfare Fund use only

Input _____ **Update** _____

Dental _____ **EPO** _____