CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

12 E. ERIE STREET, CHICAGO, ILLINOIS 60611 PHONE (312)787-9455, OPTION #4
FAX (312)951-3986 EMAIL PENSION@CRCCBENEFITS.ORG

RETIREE HEALTH BENEFITS CANCELLATION FORM – DEPENDENT

The cancellation form must be returned to the Retirement Benefits Department by the fifteenth (15th) day of the month prior to the month that you wish to cancel coverage.

Participant's Name (PLEASE PRINT): _____

Participant's UID# or SS#: _____

If you cancel coverage for your dependent, the dependent may be allowed to re-enroll if the dependent maintains continuous coverage with another plan. You will be required to provide evidence of the dependent's continuous coverage in the event the dependent enrolls at a later date. Failure to provide evidence of continuous coverage means that you forfeit your rights for retiree coverage for the dependent under the Chicago Regional Council of Carpenters Welfare Fund. Adult dependent children (ages 19-26) may be allowed to re-enroll during the annual open enrollment period, generally January 15 - March 15, with coverage effective April 1st.

IMPORTANT: If an individual enrolls in dental or vision coverage, has services, and then cancels coverage before being enrolled in the coverage for at least one full year, the Trustees prohibit re-enrollment for a period of two years.

CHECK THE APPROPRIATE CIRCLE(S)

Dependent's Name _____

O I elect to CANCEL the hospital and/or medical coverage for the above listed dependent.

O I elect to CANCEL the prescription drug coverage for the above listed dependent.

O I elect to CANCEL the dental coverage for the above listed dependent.

O I elect to CANCEL the vision coverage for the above listed dependent.

Participant's Signature:_____

Date Signed by Participant:_____

(Rev 1/2019)