The National Asbestos Workers Medical Fund

Retiree Medical Coverage Suspension Election

Retiree's Name ______________________ SSN ___________________

Effective Date NAWMF Retiree Coverage __________________________

I wish to suspend NAWMF Retiree Medical Coverage for:

_____ Myself _____ My Spouse _____ Dependent(s)

Effective Date of Suspension ____________________

Suspension effective date must be at the beginning of an Eligibility Quarter
March 1, June 1, September 1, or December 1

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I understand that to qualify for reinstatement of suspended Retiree Medical Coverage in the future, I must:

- Submit written request for reinstatement to the Fund Office prior to termination of the coverage.
- Provide evidence that the individual(s) to be reinstated (myself, and/or my spouse, and/or my dependent(s)) have maintained continuous coverage under a Health plan for the entire period of the suspension. The evidence can be copies of enrollment forms or identification cards showing the coverage dates or other correspondence from the Health plan verifying the dates of coverage.
- The reinstate effective date must be the beginning of an Eligibility Quarter
March 1, June 1, September 1, or December 1

I understand that no benefits will be paid by NAWMF for medical service received during the suspension period.

Signed __________________________ Date _____________

Fund Office Use Only
Reviewed by: ______________________ _____Accepted _____Not Accepted

Comments: ____________________________________

Confirmation copy mailed to Retiree: _______________
Date

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