KENTUCKY LABORERS DISTRICT COUNCIL HEALTH & WELFARE FUND
1996 ByPass South
Lawrenceburg, KY 40342

Telephone: (502) 839-8166 **Fax: (502) 839-3558**

REQUEST TO DISENROLL ADULT DEPENDENT

(Form must be completed in full, signed and dated by Participant and Dependent, and returned to Fund Office)

I, _____, am a participant in the Kentucky Laborers District Council Health and Welfare Plan ("Plan"). I am requesting that the following dependent be disenrolled from the Plan effective on the first day _____(Month) _____(Year) after this request is received by the Plan:

Dependent's Name: _____ Dependent's Date of Birth: _____

Dependent's Relationship to Participant: _____

Dep. Address: _____

_____

The reason I am requesting that my dependent be disenrolled is:

_____

_____

I understand that my dependent will not be eligible for COBRA coverage because the voluntary opting out of coverage is not a qualifying event under COBRA.

I understand and acknowledge that I will not be permitted to reenroll my dependent at any time in the future unless my dependent qualifies for Special Enrollment under HIPAA.

I am also confirming that I am not aware of any court order or legal obligation requiring me to continue my dependent's coverage under the Plan. I agree to hold the Plan harmless for any action it or its agents takes in reliance upon this request.

_____ _____
Participant Signature Date

_____ _____
Dependent Signature Date