Day Care Council of NY - Local 205, DC 37 Welfare Fund

Employee Benefits Trust

ENROLLMENT WAIVER

I, the undersigned, hereby certify that I have been afforded an opportunity to enroll in either the MetroPlus GoldCare I or Metro Plus GoldCare II or Out of Area Group Health Insurance offered by Day Care Council of NY - Local 205, DC 37 Welfare Fund and after careful consideration have decided not to enroll and waive my right to such coverage.

I voluntarily waive enrollment in the Welfare Fund and its benefits and I acknowledge that in the event I then become sick, incur medical expenses and need health insurance, this plan will not be available to me and I will hold harmless the Day Care Council of NY - Local 205, DC 37 Welfare Fund, the Day Care Council of New York and my day care center employer for any claim that may have been paid had I had elected enrollment in the Welfare fund and its health insurance plan(s).

Furthermore, I understand that I will not be able to join the Welfare fund and its health insurance plan at a later date (other than during the annual open enrollment period) unless I experience a qualifying event that would allow me the opportunity to enroll, provided I request the enrollment/change within 60 days of the event. I will however be enrolled in MetroPlus GoldCare I, if I lose my other health coverage and do not notify my employer and the welfare fund office.

Qualifying Life Events

A Qualifying Life Event, as defined by IRS regulations, allows you to make a change to your benefit coverage 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 your current coverage or loss of a spouse's coverage
- Judgment, decree or court order

Please fill in all information on reverse side of this form

I decline enrollment in the Day Care Council of NY- Local 205, DC 37 Welfare Fund health coverage and have attached the required proof of other insurance coverage.

Employee Signature _____ Job Title _____ Hire Date _____

Print Name _____ Birth Date _____ Social Security Number _____

Home Address _____

Home Telephone Number _____ Day Care Center Name _____

Notarized by _____ Date _____

Gray section to be completed by Day Care Center Director/Bookkeeper

Center Code # _____

Center Name _____

Center Address _____

Center Telephone Number _____

Above is certified by:

Print Name _____ Title _____

Signature _____ Date _____

Please keep copy and mail original form to:

DCC of NY – LOCAL 205, DC 37 WF, 420 W 45TH ST 3 FL, New York NY 10036-3501

Welfare Fund use only

Input _____ **Update** _____

Dental _____ **Health Plan** _____