



Bricklayers & Allied Craftworkers Local 9 Welfare Fund of Western PA
PO Box 160
Troy, MI 48099-0160
Phone: (412) 317-6538 or Toll Free: (877) 270-1199
www.BACLocal9Benefits.org

Dear Participant,

We have received your request to remove the dependent indicated below from your healthcare coverage through the Fund.

To complete the removal of this dependent, please complete this form in full; have it notarized and return to our office for processing.

To be completed by Participant:

I, _____, social security number xxx-xx-_____, request that my dependent,
(Name of Participant)
_____ to be removed from y healthcare coverage.
(Name of Dependent)

To be completed by Dependent:

I, _____, social security number xxx-xx-_____, acknowledge that
(Name of Dependent)
my parent has directed the Fund Office to remove me from his/her coverage with the Fund. I agree to this removal because I have other group health coverage that provides minimum value coverage, which means that it covers at least 60% of the total allowed cost of benefits provided under the Plan and that it provides substantial coverage for patient care and physician services.

(Dependent Signature)

(Date)

I understand that reinstatement of coverage at a later date may require approval by the Board of Trustees

Reason for Removal (Select All That Apply)

- Other Coverage (Submit copy of other insurance identification card)
- Divorced (Submit copy of divorce decree)
- No longer living in my household (Please explain) _____
- Marriage (Provide Date) _____
- Other (Please specify) _____



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(Participant's Signature)

(Date)

(Dependent Signature)

(Date)

To be completed by the Notary Public

I, _____ have witnessed the signing of this form and placed by
signature and seal as proof. My commission expires on _____

(Notary Public Signature)

(Date)