THE EMPLOYEE PAINTERS' TRUST HEALTH & WELFARE FUND

Date: _____

Voluntary Disenrollment—Waiver of Health Care Coverage

For Dependent Child Who Has Reached Age of Majority in State Where Child Resides

Participant's Name: _____
Participant's Social Security Number: _____
Participant's Street Address: _____
City, State, Zip: _____

Name of Dependent Child (*completing this form*): _____

PLEASE READ CAREFULLY BEFORE SIGNING

This is a legally binding document. The purpose of this document is to waive my coverage as the dependent child from The **Employee Painters' Trust Health and Welfare Plan ("Plan")**. By signing this document, I hereby waive and relieve the Plan from any liability or obligation for claims that may result if I were covered under the Plan.

The Effective Date is the first day of the month following the date that the request is approved by the Trust Office.

As the Dependent Child, I acknowledge, agree, and represent that all the following are true:

- I am the dependent child. Age: _____ State of My Residence: _____
- I do not wish to be covered by The Employee Painters' Trust Health and Welfare Plan.
  Effective Date: _____.
- I understand that if I sign this form, I will not be eligible for coverage for claims incurred on and after the Effective Date noted above.

I hereby waive my **coverage and known rights to benefits** from The Employee Painters' Trust Health and Welfare Plan.

_____ _____
Dependent Child's Signature Date

THIS DOCUMENT MUST BE NOTARIZED. PLEASE SIGN AND HAVE THE SECTION BELOW COMPLETED, SIGNED AND SEALED BY A NOTARY PUBLIC.

Subscribed and sworn to before me this _____ day of _____, 20_____.

_____ My commission expires:

(Notary Seal)

_____ 20_____

County _____ State _____

(OVER)

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PROVIDE THE REASON FOR THE REQUEST TO VOLUNTARILY DISENROLL:

_____

_____

_____

_____

TAX CONSEQUENCES

Participants and dependents should be advised that there may be adverse tax consequences under the Affordable Care Act if you do not maintain qualifying minimum essential coverage. You should consult your tax professional or lawyer for appropriate advice before choosing to voluntarily disenroll from coverage under this Plan.

REINSTATEMENT PROVISION

If a dependent child is removed under this provision, he or she may only regain coverage under the applicable enrollment if requested by the participant by submitting a new enrollment form to the Trust Office. The participant must also provide written consent to reinstatement of coverage from the dependent child and demonstrate eligibility of the dependent child as an eligible dependent under the Plan. Coverage will commence in the month following completion of reenrollment.