THE EMPLOYEE PAINTERS' TRUST HEALTH & WELFARE FUND

Date: _____

Voluntary Disenrollment—Waiver of Health Care Coverage
DEPENDENT SPOUSE

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

Name of Spouse: _____

PLEASE READ CAREFULLY BEFORE SIGNING

This is a legally binding document. The purpose of this document is to waive your spouse's coverage from The **Employee Painters' Trust Health and Welfare Plan ("Plan")**. By signing this document, you hereby waive and relieve the Plan from any liability or obligation for claims that may result if your spouse was 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.

The undersigned hereby acknowledges, agrees, and represents that all the following are true:

- Spouse's Name: _____ is my Spouse.
- I do not wish my Spouse to be covered by The Employee Painters' Trust Health and Welfare Plan. **Effective Date:** _____.
- I understand that if I sign this form, my Spouse will not be eligible for coverage for claims incurred on and after the Effective Date noted above.

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

_____ _____
Spouse's Signature Date

_____ _____
Participant'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 SPOUSE:

_____

_____

_____

_____

(NOTE: If your dependent spouse is being voluntarily disenrolled from Plan coverage under the Plan's voluntary disenrollment provisions in anticipation of divorce, you and your dependent spouse must notify the Trust Office when your divorce has become final.)

TAX CONSEQUENCES

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

REINSTATEMENT PROVISION

If your Spouse 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 Spouse and demonstrate eligibility of the Spouse as an eligible dependent under the Plan. Coverage will commence in the month following completion of reenrollment.