AUTHORIZATION FOR SELF PAYMENT DEDUCTION

Please reduce my monthly Pension check by the amount of my monthly self-payment, in order to continue my benefits in the Northern California Sheet Metal Workers Health Care Plan. This amount is to be applied against my self-payment contribution to the Insurance Fund.

Date _____ Signature _____ Social Security Number _____

YOU MUST NOTIFY THE FUND OFFICE OF ANY CHANGES FOR YOUR INSURANCE. AN EXAMPLE WOULD BE WHEN THE MEMBER OR SPOUSE BECOMES EFFECTIVE FOR MEDICARE BENEFITS.

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DO NOT SIGN BELOW THIS LINE IF YOU WISH TO CONTINUE COVERAGE

WAIVER ELECTION

I wish to terminate my Health Insurance benefits with the Northern California Sheet Metal Workers Health Care Plan as of _____, 20__. I realize that this form serves to waive any liability that the Northern California Sheet Metal Workers Health Care Plan might have and the specific Health Insurance Company that I currently have a policy with. I am waiving my right to have the health insurance at this time, and realize that reinstatement for coverage may only be done in accordance with the Plan rules and regulations. **If you wish to delay coverage at this time please provide proof of current coverage under your spouse's group plan.**

Date _____ Signature _____ Social Security Number _____