NATIONAL IAM
BENEFIT TRUST FUND

# ELECTION AND WAIVER OF BENEFITS

I, the undersigned, have been informed that I am eligible for the following coverage through the National IAM Benefit Trust Fund (*only those marked with an x*):

☐ **Medical** ☐ **Dental** ☐ **Vision**

☐ **Short Term Disability** ☐ **Life and AD&D**

I understand that my employer, _____ may make payroll deductions toward the cost of some or all of this coverage.

I elect to take or waive coverage through the National IAM Benefit Trust Fund as follows (*complete this section only for the eligible coverage types that are marked above*):

| Coverage Type | I want this coverage | I do not want this coverage | I have other group coverage of this type |
|---|---|---|---|
| **Medical** | ☐ Elect Coverage | ☐ Waive Coverage | ☐ Yes ☐ No |
| **Dental** | ☐ Elect Coverage | ☐ Waive Coverage | ☐ Yes ☐ No |
| **Vision** | ☐ Elect Coverage | ☐ Waive Coverage | ☐ Yes ☐ No |
| **Short Term Disability** | ☐ Elect Coverage | ☐ Waive Coverage | ☐ Yes ☐ No |
| **Life and AD&D** | ☐ Elect Coverage | ☐ Waive Coverage | ☐ Yes ☐ No |

**If I waive any coverage for myself or my dependents, I understand that I will not be entitled to reinstate that coverage through the National IAM Benefit Trust Fund until my employer's annual open enrollment period** *(or if my employer does not have an open enrollment period, an annual enrollment period assigned by the Benefit Trust Fund).*

However, I understand that I may specially enroll before my employer's open enrollment period *(or assigned annual enrollment period)* if I am declining any coverage because I am currently covered by another group health plan as an employee, retiree, or dependent, and that coverage is later terminated because of legal separation, divorce, death, termination of employment, reduction in the number of hours of employment, termination of employer contributions toward the cost of the other coverage, an increase in the subscriber's cost for the other coverage, or the exhaustion of COBRA coverage.

I further understand that if my other coverage is exhausted for any of the above reasons, I must provide evidence of such termination to the National IAM Benefit Trust Fund, and request a special enrollment no later than **30 days** after the date my other coverage is exhausted.

_____ _____

Employee Name – Please Print | Social Security Number

_____ _____

Employee Signature | Date Signed

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