

Roofers' Local #195  
Health, Accident & Pension Funds  
6200 State Route 31 Cicero, NY 13039  
Phone: (315) 699-1388 Fax: (315) 699-1390

---

**Spousal Insurance Option Election/Rejection Form**

Member Name: \_\_\_\_\_  
Spouse Name: \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_  
P.O. Box: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Dear Spouse:

This letter is to inform you of your insurance options due to the implementation of the Spousal Insurance Opt-Out Rule.

Your Spousal Insurance Opt-Out Form indicates that you fall within the guidelines established by the Fund Office. Our Fund coordinates plans regardless of whether your spouse elects his/her employers health coverage.

In the event that you do not wish to purchase/acquire your own medical coverage through your employer, you will be required to submit a Summary Plan Description which contains a detailed outline of the medical coverage's you have refused, so that we may coordinate benefits just as though your insurance were in effect and primary on you. In other words, we will be making the co-pays just as though you had purchased the medical insurance policy on yourself, from your employer, and you will be responsible for the balances, which would have otherwise been covered by your insurance.

\_\_\_\_\_ Check here if you have elected to purchase/acquire medical coverage with your employer. Please attach copies of your insurance cards and indicate what coverage's you have chosen by checking all that apply:

Medical:	_____ Family	_____ Self	Effective Date: _____
Dental:	_____ Family	_____ Self	Effective Date: _____
Prescription:	_____ Family	_____ Self	Effective Date: _____
Vision:	_____ Family	_____ Self	Effective Date: _____

\_\_\_\_\_ Check here if you have chosen not to purchase/acquire medical coverage with your employer. Please enclose a copy of your Plan Summary Description Booklet so that we may coordinate claims accordingly. No claims will be processed effective January 1, 2003 without this Coordination of Benefits information on file, if this option is chosen.

Spouse Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Sincerely,  
The Fund Office Staff