UNITED FOOD AND COMMERCIAL WORKERS UNION AND PARTICIPATING FOOD INDUSTRY EMPLOYERS HEALTH AND WELFARE FUND

27 ROLAND AVENUE, SUITE 100
MOUNT LAUREL, NJ 08054-1056

(800) 228-7484 • (856) 793-2500 • FAX: (856) 793-3102

DENTAL AND VISION COVERAGE OPT-OUT FORM

EMPLOYEE INFORMATION

Employee (Participant) Last Name	First Name/Middle Initial	Sex ☐M ☐F	Date of Birth / /	Social Security Number
Employee (Participant) Address	City / State / Zip			Phone Number

Name of Employer	☐ Full time ☐ Part time	Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced	Local Union Number	Date of Hire / /

Signature and Authorization to Permanently Terminate Dental and Vision Coverage

By signing this form, I permanently and completely terminate and waive current and/or future rights to dental and vision coverage through U.F.C.W. Health and Welfare Fund for myself and any eligible family members, if applicable. I understand that I am opting out of coverage for which I may otherwise be eligible, and that no money is due to me based on my decision to affirmatively opt-out of this coverage.

Employee/Participant Signature _____	Date _____