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

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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. Tri-State 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 _____