PIPELINE INDUSTRY BENEFIT FUND
REVOCATION OF REFUSAL AND WAIVER OF COVERAGE (OPT-IN)

As a Participant in the Pipeline Industry Benefit Fund, I acknowledge that I am eligible for certain medical and related benefits (includes medical, prescription, HRA, dental, & vision coverage) subject to the eligibility and coverage provisions of the Plan. If I previously refused and waived coverage for myself, I understand that I may rescind and revoke the previous waiver of coverage for my Dependent(s) only if I also rescind and revoke the previous waiver of coverage for myself.

I previously elected to expressly refuse and waive any and such coverage or benefits on behalf of the individuals listed below that now elect to rescind and revoke the previous waiver of coverage, which will be effective the first day of the month after receipt by the Fund Office, provided the revocation of the waiver is received no later than the 15th day of the prior month. I further acknowledge that this decision, jointly agreed upon by my spouse (if any), to revoke the waiver of coverage for myself (opt-in), my spouse and/or one or more of my Dependent children was/is an intentional, knowing, and a voluntary decision of mine/ours, made without any request, suggestion, coercion, or act by or on behalf of the Trustees of the Plan or any person or agent acting for or on their behalf. I/we acknowledge and represent that this revocation of waiver of coverage is based upon and due to the fact that I and/or any Dependent is, or will be, ineligible for coverage of certain medical and/or related benefits from some another source that offers affordable minimum essential coverage that provides minimum value, and I agree to furnish documentation of such coverage from the date of the waiver of coverage through the date of the revocation of such waiver.

By each signing below, I/we hereby acknowledge and agree that my/our decision to revoke the waiver of coverage or benefits (opt-in) for myself or each of my eligible Dependents listed below (including my spouse, if any) will remain in effect.

I understand I can opt-in one time only. The individuals for whom revocation of waiver of coverage (opt-in) is requested are:

Print Name*	SSN	Relationship	Date of Birth	Address
Print Name*	SSN	Relationship	Date of Birth	Address
Print Name*	SSN	Relationship	Date of Birth	Address
Print Name*	SSN	Relationship	Date of Birth	Address

***Removal of a dependent child (age 18 to 26) or a spouse requires their signature before a Plan Representative or Notary.**

The undersigned acknowledge that the above information is correct, and that the Employee/Participant is revoking a waiver of coverage on behalf of the individuals listed above, that they understand the consequences of the revocation of the waiver of coverage.

_____	_____	_____
Date	Employee/Participant	Print Name
_____	_____	_____
Date	Spouse of Employee/Participant	Print Name
_____	_____	_____
Date	Adult Child of Employee/Participant	Print Name

Subscribed and sworn to before me this _____ day of _____, 20____.

_____
Signature of Notary