PIPELINE INDUSTRY BENEFIT FUND
REFUSAL AND WAIVER OF COVERAGE (OPT-OUT)
(Available beginning January 1, 2025)

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. I also understand that upon my refusal and waiver, coverage for my Dependents will also terminate. I also understand that I may refuse and waive coverage solely for my Dependent(s) while I maintain coverage for myself under the Plan.

I/we hereby expressly refuse and waive any and such coverage or benefits on behalf of the individuals listed below, which will be effective the first day of the month after receipt by the Fund Office, provided 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 refuse coverage for myself, 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 refusal and waiver of coverage is based upon and due to the fact that I and/or any Dependent is, or will be, eligible 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.

I acknowledge that contributions have been, and will continue to be, made on my behalf pursuant to the Collective Bargaining Agreement or Participation Agreement, if applicable, and remitted to the Plan. I understand that, based on choosing to opt-out at this time, I will not be eligible for COBRA nor any premium assistance tax credit on the health care exchange. The Waiver of Coverage request may be rejected by the Fund if doing so it is deemed necessary by the Fund to ensure compliance with Medicare secondary payer laws.

By each signing below, I/we hereby acknowledge and agree that my/our decision to refuse and coverage or benefits for myself or each of my eligible Dependents listed below (including my spouse, if any) will remain in effect until otherwise rescinded or revoked, which coverage will recommence after receipt of the written recission by the Fund Office, on a form satisfactory to the Trustees.
I understand I can opt-out one time only. The individuals for whom coverage is refused and waived 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 refusing and waiving coverage on behalf of the individuals listed above, that they understand the consequences of the refusal and waiver of coverage, and that this refusal may be rescinded and revoked in writing.

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