NECA/IBEW FAMILY MEDICAL CARE PLAN
410 Chickamauga Avenue, Suite 301
Rossville, GA 30741
http://www.neca-ibew-healthcare.com

Phone (706) 841-7000 Fax (706) 841-7020 Toll Free (877) 937-9602

DISENROLLMENT FORM

Participant Name: _____
Last, First, Middle

Participant Address: _____
Street Address

_____
City, State, Zip Code

I wish to disenroll the following dependents from coverage under the NECA/IBEW Family Medical Care Plan:

Name (Last, First, Middle):_____ Date of Birth: ___/___/_____

Name (Last, First, Middle):_____ Date of Birth: ___/___/_____

Name (Last, First, Middle):_____ Date of Birth: ___/___/_____

I understand that effective immediately, these individuals will be disenrolled in coverage under the Plan and will not be entitled to any benefits under the Plan. I further understand that the Plan is not responsible for the payment of any medical claims made on behalf of these dependents after their disenrollment.

I certify that I have read the Plan's Disenrollment and Re-Enrollment Rules & Procedures and understand the consequences of my decision to disenroll myself and/or my dependents and the limitations on my rights to be re-enrolled in the Plan.

I agree, to the extent permitted under applicable law, to hold the Plan harmless against any and all taxes, penalties, fees and expenses incurred as a result of my choosing to disenroll my dependents from coverage under the Plan.

Participant Signature: _____ **Date:** _____

Dependent / Spouse Signature: _____ **Date:** _____

Please return the signed Disenrollment Form to the Benefit Office at the address listed above.