



National Asbestos Workers Medical Fund

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Retiree Medical Coverage Suspension Election

Retiree's Name:		SSN (last 4 digits):	
National Asbestos Workers Medical Fund Coverage Effective Date:			
I wish to suspend Retiree Medical Coverage for: (check all that apply)			
<input type="checkbox"/> Myself <input type="checkbox"/> My Spouse <input type="checkbox"/> Dependent (s)			
Effective Date of Suspension*:			

***Suspension Effective Date must be at the beginning of an Eligibility Quarter; March 1, June 1, September 1, or December 1. Requests must be submitted at least 14 days prior to the requested suspension date.**

I understand that to qualify for reinstatement of suspended Retiree Medical Coverage in the future, I must:

- Submit a written request for reinstatement to the Fund Office **30 days prior to the requested reinstatement date.**
- Provide evidence that the individual(s) to be reinstated (myself, and/or my spouse, and/or my dependent(s)) have maintained continuous coverage under a Health plan for the entire period of the suspension. The evidence can be copies of enrollment forms or identification cards showing the coverage dates or other correspondence from the Health plan verifying the dates of coverage.
- The reinstatement effective date must be the beginning of an Eligibility Quarter; March 1, June 1, September 1, or December 1.

I understand that no benefits will be paid by the National Asbestos Workers Medical Fund for claims incurred during the suspension period.

Retiree Signature: _____ Date: _____

Spouse Signature: _____ Date: _____