Insulators and Allied Workers National Medical Fund
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Administered by:
NEBA

Retiree Medical Coverage Reinstatement Election

Retiree's Name:		**SSN (last 4 digits):**	
Insulators and Allied Workers National Medical Fund Coverage Effective Date:			
I wish to reinstate Retiree Medical Coverage for: (check all that apply)			
☐ Myself ☐ My Spouse ☐ Dependent (s)			
Effective Date of Reinstatement*:			

***Reinstatement Effective Date must be at the beginning of an Eligibility Quarter; March 1, June 1, September 1, or December 1.**

I understand that to qualify for reinstatement of suspended Retiree Medical Coverage I must:

- Submit this 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.

Signed _____ Date _____