Insulators and Allied Workers National Medical Fund
2010 N.W. 150th Avenue, Suite 200 | Pembroke Pines, FL 33028
Toll Free: (888) 352.0629 | West Coast Toll Free: (888) 987.0629
Fax: (954) 266.2079 | www.nebainc.com

Administered by:
NEBA

Retiree Medical Coverage Suspension Election

Retiree's Name:		**SSN (last 4 digits):**	
Insulators and Allied Workers National Medical Fund Coverage Effective Date:			
I wish to suspend Retiree Medical Coverage for: (check all that apply)			
☐ Myself ☐ My Spouse ☐ 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 Insulators and Allied Workers National Medical Fund for claims incurred during the suspension period.

Retiree Signature: _____ Date: _____

Spouse Signature: _____ Date: _____