**************************CONJUNCT ONLY*************************

# EMPLOYEE'S REQUEST TO DECLINE COVERAGES UNDER THE LABORERS' DISTRICT COUNCIL OF WESTERN PENNSYLVANIA WELFARE FUND BENEFIT PLAN AND WAIVER OF CLAIMS FORM

I elect to decline all benefit coverages available to me and my eligible dependents through my employer under the Laborers' District Council of Western Pennsylvania Welfare Fund ("Welfare Fund") Benefit Plan, including but not limited to health coverage benefits, life insurance, weekly sickness and accident benefits and accidental death and dismemberment benefits. I do so freely and voluntarily, with the understanding that I am legally bound by and subject to the following provisions:

1. My dependents and I have other health care coverages available and I want us to be covered by such other coverages, with which we are fully satisfied.

2. I understand that I will be required to present proof of the other health care coverages to my employer, as well as to the Welfare Fund, prior to my being permitted to cancel the coverages available to me and my eligible dependents under the Welfare Fund's Benefit Plan.

3. I understand the benefits which would otherwise be available to me and my eligible dependents under the Welfare Fund Benefit Plan, and I acknowledge that I have been given the opportunity to obtain information about or seek answers to any questions I might have about the benefits available from the Welfare Fund prior to exercising this right to decline such coverages for myself and my eligible dependents.

4. I understand that if I desire to enroll myself and my eligible dependents in the future for Welfare Fund Benefit Plan coverages, I have no guarantee that I may do so except (1) upon a "loss of eligibility" for other group health plan or health insurance coverage or if employee contributions toward the other coverage cease, as provided by federal law, and (2) I am otherwise eligible for coverage under the Welfare Fund's Benefit Plan. "Loss of eligibility" includes loss of other coverage due to legal separation, divorce, voluntary or involuntary termination of employment, reduction in hours, children aging out of coverage, or moving out of an HMO service area. It does not include loss of coverage due to failure of the individual to pay timely premiums or termination of coverage for cause. I also understand that I may have to submit proof of my health status or that of my eligible dependents at the time relating to insurability, and that in doing so I may have to incur expense. I also understand that even if I am determined to be eligible for enrollment in the Welfare Fund Benefit Plan in the futures, there may be a waiting period before any benefits available under the Benefit Plan actually take effect.

**OVER**

5. I understand that any payment or benefit I receive from my employer as a result of my voluntary election to decline Welfare Fund Benefit Plan coverages may be subject to federal, state and local taxes, in addition to those deducted from my regular wages.

6. On behalf of my eligible dependents and myself, I hereby waive and relinquish any claim against my employer, the Laborers' District Council of Western Pennsylvania and its Local Unions, the Welfare Fund, and all of their employees, officers, Trustees and representatives, from any type of claim or liability, of any nature, relating to or resulting from my exercise of my right to decline coverages and benefits under the Welfare Fund Benefit Plan.

7. I have carefully read the above statement and I clearly understand all parts of it.

_____ _____

Witness Signature of Employee

_____

Printed Name of Employee

_____

Social Security Number of Employee

_____

Company Name

_____

Date

IF THERE ARE ANY QUESTIONS ABOUT WELFARE FUND BENEFIT PLAN COVERAGES AN EMPLOYEE MAY CONTACT THE FUND AT 1-800-242-2538.