Laborers' COMBINED FUNDS OF WESTERN PENNSYLVANIA
Serving the Laborers' District Council of Western Pennsylvania
Pension Fund, Welfare Fund and other affiliated Funds
12 EIGHTH STREET, SUITE 500 • PITTSBURGH, PENNSYLVANIA 15222
PHONE: 1-412-263-0900 • www.lcfowpa.com

REQUEST TO TERMINATE MEDICAL COVERAGE OF A CONJUNCT COVERED DEPENDENT UNDER WELFARE FUND BENEFIT PLAN

I, _____, S.S.No. _____-_____-_____, of
(Member's name)

_____, request
(Member's address)

that the medical coverage under the Laborers' District Council of Western Pennsylvania Welfare Fund Benefit Plan be terminated effective _____ for my spouse
(Date)
_____ and/or my child(ren)
(Name of spouse)

_____as (a) covered dependent(s).
(Name(s) of child(ren)

I understand that I could be ordered by a court to pay for the medical insurance and medical bills of my spouse and children.

I hereby certify that there is no current Court Order, which directs me to provide medical coverage for the above named spouse and/or child(ren). I agree to provide to the Welfare Fund a copy of any such Order that I may receive.

I hereby certify that the current address of the above-named spouse and/or child(ren) is _____
(Address)

and the telephone number is (_____) _____ - _____.

OVER

I certify that I **do not** know the current address and/or telephone number of the above named spouse and/or child(ren), but the name and address/telephone number of a close friend or relative of my spouse and/or child(ren) is _____
(Name)

_____ (_____)_____-_____.
(Relationship) (Telephone number)

_____
(Address)

*****A COPY OF THE DEPENDENT'S INSURANCE CARD IS REQUIRED TO TERMINATE COVERAGE****

VERIFICATION

I hereby state that the above statements are true and correct to the best of my information, knowledge and belief and are made subject to the penalties of 18 Pa. C.S.A. 4904 relating to unsworn falsification to authorities.

_____ _____
(Member's signature) (Date)

(_____) _____-_____
(Member's telephone number)