OPERATING ENGINEERS LOCAL 139

HEALTH BENEFIT FUND

N27 W23233 Roundy Drive • P.O. Box 160 • Pewaukee, WI 53072-0160

Phone: (262) 549-9190
Toll Free: (800) 242-7018
Fax: (262) 549-3549

Affidavit Requesting Termination of Coverage – Adult Dependent

Dependent Name:____

Street Address:____

City, State, Zip:____

Name of Local 139 Member with Primary Coverage:______________________

I swear or affirm:

1. That I am requesting a termination of my coverage as dependent under the Operating Engineers Local 139 Health Benefit Fund (the Fund), with an effective termination date of ____________________. I understand that this date must be at least three (3) business days in advance of today's date in order for the Fund to have time to process my termination request.

2. Any and all claims with date of service on or after the date listed in paragraph 1 above to present that were paid from the Fund will be recalled for refunds. If such claims have not yet been paid, those claims will not be paid by the Fund and will be processed as ineligible or denied claims. If the Fund erroneously pays such a claim I understand that the Fund may recoup the claim from me, or others, or have it be reversed.

3. That it is my responsibility to notify any and all providers of this termination of coverage and request resubmission of any and all claims. I understand that I may have some financial liability with respect to the claims of these providers. I understand that if I have other insurance, or obtain other insurance, that the other insurance may not pay these claims at all, or may pay only a portion of the claims, leaving me with the responsibility to pay the complete or partial balance.

4. That I will notify any third party which provides health coverage or assistance towards health coverage (including, but not limited to, Medicare, Medicaid and BadgerCare) of the cessation of my Fund coverage, if so required by applicable law or that third party's rules. I am not requesting the termination of the Fund coverage for any fraudulent or unlawful purpose, nor have I notified the Fund of such situation. The Fund makes no guarantees or representations about my eligibility, or continuing eligibility, for any third party health coverage or assistance towards health coverage.

5. This termination request was made voluntarily, of my own free will. I will not claim that the termination violates any applicable law, agreement, plan or understanding.

(Continued on next page)

I swear or affirm that the above and foregoing representations are true and correct to the best of my information, knowledge, and belief.

____ _______________________

Dependent Signature Date

Notary Acknowledgment

State of __________________________________

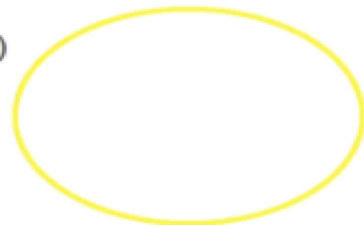
County of ________________________________

I, the undersigned Notary Public, do hereby affirm that ________________________________
Dependent Name Listed Above

personally appeared before me on ____________________, and signed the above Affidavit as
Date

his/her free and voluntary act and deed.

(Seal, if any)



____
Notary's Signature

____
State and Commission Expiration Date

Please mail this form to P.O. Box 160, Pewaukee WI 53072-0160 or fax to 262-549-3549.