AFFIDAVIT REQUESTING TERMINATION OF COVERAGE

Name: _____

Street Address: _____

City, State, Zip Code: _____

Name of Person with Primary IUOE139 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.

(Continued on next page)

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.

I SWEAR OR AFFIRM THAT THE ABOVE AND FOREGOING REPRESENTATIONS ARE TRUE AND CORRECT TO THE BEST OF MY INFORMATION, KNOWLEDGE, AND BELIEF.

Signature:_____ **Date:** _____

STATE OF _____

COUNTY OF _____

I, the undersigned Notary Public, do hereby affirm that _____
(name of person listed above)

personally appeared before me on_____, and signed the above Affidavit as his/her free
(date)
and voluntary act and deed.

Notary Public

_____
(Notary's Signature)

_____
(State and commission expiration date)