Theatrical Stage Employees Health & Welfare Trust

2815 2nd Avenue, Suite 300 • P.O. Box 34203 • Seattle, Washington 98124-1203
Phone (206) 441-7574 or (800) 732-1121 • Fax (206) 505-WPAS (9727) • Website: www.IA15Trust.com

Administered by
Welfare & Pension Administration Service, Inc.

2016 Waiver of Health Coverage and Acknowledgement

I acknowledge that I have been offered the opportunity to enroll in health coverage from the Theatrical Stage Employees Health and Welfare Trust for myself and my dependents. I understand that this coverage meets the Minimum Value and Affordability requirements of the **Affordable Care Act** and neither myself or family members are eligible for a federal premium subsidy should we elect to purchase a **Qualified Health Plan** from the **Washington Health Benefit Exchange.**

I decline enrollment at this time because:

☐ I have other group medical coverage provided by:

Insurance company name: ________________________________ Policy no. ______________

Through (employer or plan name): ____

☐ I have other government medical coverage such as: ☐ Medicare ☐ Tricare ☐ Medicaid

Please provide evidence of other coverage in the form of a copy of a current ID card.

If you are declining enrollment for yourself or dependent(s) because of other health care coverage, you may be able to enroll yourself or your dependents in this plan if you or your dependent(s) lose eligibility for that other coverage (or an employer stops contributing towards other group coverage), provided that you request enrollment within 31 days after you or your dependent's other coverage ends (or employer contributions stop). In addition, if you waive enrollment under this plan at this time and later acquire a new dependent due to marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependent(s) under this plan, provided you request enrollment within 31 days after the marriage, or within 60 days after the birth, adoption, or placement for adoption. Please contact the Plan Administrator if you require further information.

I understand that I and/or any of my dependent(s) will be unable to obtain coverage under the Theatrical Stage Employees Health and Welfare Trust health plan until the next annual open enrollment period, unless I and/or my dependent(s) qualify for a special enrollment period.

I understand that by declining enrollment in the Theatrical Stage Employees Health and Welfare Trust health plan, I forfeit my and my employer's contributions to the Trust which would have been used toward payment of the health plan premiums.

Printed name: ____

Signature: ____ Date: __________________