North Atlantic States Carpenters
Health Benefits Fund

Buffalo Office
1159 Maryvale Dr., Suite 20
Cheektowaga, NY 14225
Phone: (716) 839-7132
Toll Free: 1(877) 739-7136
Fax: (716) 839-7136
www.carpentersfund.org.

South Central Office
181 Industrial Park Road
Horseheads, NY 14845
Phone: (607) 739-1326
Toll Free: 1(866) 727-0281
Fax: (607) 739-1415
www.carpentersfund.org

OPT OUT APPLICATION

MUST BE COMPLETED AND RETURNED FOR NO COVERAGE

In order to opt-out of medical and prescription coverage provided by the North Atlantic States Carpenters Health Benefits Fund, you must complete this form verifying that your other medical/prescription coverage is a group health plan that meets the minimum value standard of the Affordable Care Act ("ACA") for yourself and each of your otherwise eligible dependents.

Please be advised that any NYS sponsored or government funded plans, such as Medicaid, are NOT acceptable and cannot be used to opt out of coverage through the North Atlantic States Carpenters Health Benefits Fund.

I, _____ am electing to opt out of the medical/prescription coverage with the North Atlantic States Carpenters Health Benefits Fund.
Last 4 digits of SS#_____.

_____Dental Coverage Only (**check to keep existing or attach enrollment application for new**)

STATEMENT OF OTHER MEDICAL COVERAGE

_____ is insured by, _____
(*Subscriber of medical coverage)* *(Insurance company name on card)*

and receiving medical/prescription coverage from, _____ *(example- self, parent or spouse)*

Medical (Single)_____ (Family)_____ ***Vision (Single)_____ (Family)_____***

Dental (Single)_____ (Family)_____ ***Prescription (Single)_____ (Family)_____***

Is this an employer group health plan? _____

Effective Date:_____ Term date:_____

Does this coverage meet the minimum value standards of the Affordable Care Act?_____

Is coverage with a plan purchased through a State Health Plan Marketplace?_____

Is coverage with a Medicaid plan?_____

If your plan coverage was purchased through a State Health Plan Marketplace or provided by Medicaid you will automatically be enrolled in the lowest level of medical/prescription coverage offered by the North Atlantic States Carpenters Health Benefits Fund. These plans are not group health plans as defined by the Affordable Care Act and therefore cannot be used to opt out of coverage through the North Atlantic States Carpenters Health Benefits Fund.

___ (check) He/She is enrolled in a family medical coverage or health insurance plan, which includes coverage for:

_____ _____

Dependent name *Dependent name*

_____ _____

Dependent name *Dependent name*

I have read the statements above and I attest to the following:

- As of the date indicated below, I am enrolled in a group health plan that meets the minimum value standard of the Affordable Care Act.
- I understand that I must notify the Fund immediately if and when I am no longer enrolled in a group health plan that meets the minimum value standard of the ACA.
- I agree to indemnify the Fund and its Trustees from any losses caused by any misstatements made herein.

_____ _____

Member Signature Only Date

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