WAIVER OF EXISTING COVERAGE
UNDER THE
SOUTHERN CALIFORNIA LUMBER INDUSTRY WELFARE FUND

I understand that I am waiving existing coverage in the Southern California Lumber Industry Welfare Fund for myself and/or my eligible dependents, if any, as I/we are currently covered (including COBRA) under other group health coverage. I have enclosed proof of our other coverage.

The name and address of the entity providing this coverage is_____
The policy or group number is_____.
Phone No._____

I understand that should I/we lose current coverage under this other group health coverage, for example, as a result of:

- Termination of employment of the person through whom I/we have coverage
- Termination of the plan of coverage
- Cessation of the employer's (or other third person) contribution towards an employee or dependent coverage
- Legal separation
- Divorce
- Loss of dependent status
- Reduction in hours of employment
- As a covered employee, a court has ordered that coverage be provided for a spouse or minor child
- Exhaustion of COBRA coverage

I/we will be allowed to re-enroll in the Welfare Fund but I must enroll myself and my eligible dependents, under the Waiver and Re-enrollment Rights for Employees with Coverage under this Plan contained in the Plan's Summary Plan Description and Plan Booklet. You may also call the Administrative Office at (562)463-5080 for assistance and additional details on re-enrollment in the Welfare Fund. Please note there are special eligibility requirements and conditions of re-enrollment (including the payment of the required monthly contributions by my employer) that apply.

I have read this waiver of coverage form and the applicable provisions of the Summary Plan Description and Welfare Fund Plan Booklet and understand the consequences of waiving existing coverage. Waiver of this coverage constitutes a waiver of all coverage under the Welfare Fund, even if new plans are adopted.

PLEASE LIST DATA FOR SELF AND ELIGIBLE DEPENDENTS FOR WHOM COVERAGE IS TO BE WAIVED:

EMPLOYEE
NAME_____SS#_____

ADDRESS_____ DATE OF BIRTH _____

DEPENDENTS FULL NAME	SS#	DATE OF BIRTH	RELATIONSHIP

EMPLOYER NAME AND ADDRESS_____

_____

_____ _____
EMPLOYEE SIGNATURE DATE