



LOCAL 211 INTERNATIONAL UNION OF OPERATING ENGINEERS
ALLIED BUILDING INSPECTORS

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**WELFARE FUND
REQUEST TO REMOVE DEPENDANT
FROM THE WELFARE FUND**

Member Name _____ Social Security No. _____

Member No. _____

Dependent Name _____

Dependent's Date of Birth _____ Relationship to Member _____

By signing below, I, _____ request to have the above-named dependent removed from my Allied Building Inspectors Local No. 211 Welfare Fund Plan coverage.

I understand that there will be no Plan coverage, including but not limited to dental, vision and prescription, for the above-named dependent.

I understand that I am required to re-enroll the above-named dependent if I wish for them to receive coverage under the Plan and coverage will begin only after the dependent has been re-enrolled.

Name _____

Signature _____

Date _____

Personally appeared at _____, New York, this _____ day of _____, 20____, the within named _____, signer and sealer of the foregoing request who acknowledged the same to be his/her free act, before me.

Notary Public/Commissioner of the Superior Court