

Alaska United Food and Commercial Workers Trust Funds

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Administered by
Labor Trust Services, Inc.

AUTHORIZATION TO OPT-OUT OF HEALTH COVERAGE

I hereby request that my employer cease deducting the weekly employee contribution required for health coverage through the Alaska United Food and Commercial Workers Health and Welfare Trust.

When the deduction stops, I understand my coverage will end and I will not be able to re-enroll in the health plan until the next annual open enrollment period.

Employee Name (print)

I.D. number or last 4 digits of your Social
Security Number

Date of Birth

Employee Address

City State Zip

Name of Employer

Employee Signature

Date