Alaska United Food and Commercial Workers Trust Funds

375 W. 36th Street, Suite 200 • P. O. Box 93870 • Anchorage, Alaska 99509-3870
Phone (800) 478-8329 • Fax (907) 561-4802 • www.akufcwtrust.com

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

DW:adg opeiu#8
S:\Forms\Control\F45-02 - Form - 2016 - 03.10 - Opt-Out of Health Coverage Form.docx