ROOFERS LOCAL 241 SECURITY PLAN
WAIVER OF COVERAGE

Having met the eligibility requirements, you have been enrolled in health insurance coverage offered by the Roofers Local 241 Security Plan (the "Plan"). You have the right to opt-out, or waive coverage only if you present proof of major medical and hospital coverage that is employer-sponsored group coverage and that coverage provides "minimum value" as defined by the Affordable Care Act (the "ACA").

The decision to waive coverage has consequences for you. For example:

• If you waive coverage, you cannot enroll in the Roofers 241Plan until the next open enrollment (March 1 to March 31), unless you experience a qualified change in status. Examples include if you are covered under another plan, but that coverage is lost, or if you gain a new dependent through birth, adoption, or marriage. However, you must request to enroll in the Plan within 30 days of the qualified change in status. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

•If you do waive coverage for yourself, you may not cover dependents under the Plan.

I acknowledge that the Roofers Local 241 Security Plan has enrolled me in affordable minimum essential coverage, as defined under the ACA, for the period from April 1 to March 31, 2027. I have other employer-sponsored group health insurance coverage . . . (please check one)

☐as a dependent on another person's policy ☐ through my own employment

Other employer-sponsored group health insurance policy holder information:

Name of Policy Holder_____

Policy Holder's Employer_____

Effective Date of Coverage_____

(You **must** provide a copy of your health insurance card AND provide a Summary of Benefits and Coverage from your outside carrier.)

I have read the above and I understand the consequences of my waiver of coverage. I hereby elect to waive coverage under the Roofers Local 241 Security Plan.

_____
Name of Employee

_____ _____
Signature of Employee Date

As a representative of the Roofers Local 241 Security Plan, I received this Waiver of Coverage from the above employee on_____(Date).

_____
Signature of the Fund Administrator