SAMPLE

Ineligible Dependent Form

RESPONSE IS REQUIRED BY MAY 16, 2018

If any of your dependents are no longer eligible for coverage, please provide their name(s) and the reason for ineligibility below. You may alternatively leave a comment on your secure web portal with the dependent's name and reason for ineligibility by logging into www.Consova.com/IBEWNECA and clicking the "submit comment" tab. You will need your PIN number to log in to the website; your PIN number will be mailed to you.

Coverage for ineligible dependents will end as soon as administratively possible.

Ineligible Dependent Name	Ineligibility Reason

Participant's Name: ______________________________ Last 4 Digits of Social Security No.: _____

Signature of Participant: ______________________________

Date: ______________________________

By signing above, I declare under penalty of perjury under the laws of the State of California and certify to Southern California IBEW-NECA Health Trust Fund that all information on this *Ineligible Dependent Form* is true, correct and current as of the date signed.

Please mail or upload this completed and signed form if you have an ineligible dependent(s) to declare.