

**UFCW INTERNATIONAL UNION PENSION PLAN FOR EMPLOYEES**

**Rejection of Retiree Health Coverage**

1. I hereby reject the health coverage under the UFCW Health Insurance Plan for Retirees (“Plan”) that is available to me at the time of my retirement.
2. I understand and acknowledge that, pursuant to my rejection of this coverage now, I will not be permitted to elect health coverage under the Plan until the first of the month following my 60<sup>th</sup> birthday.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

Name and Address: \_\_\_\_\_

\_\_\_\_\_

**NOTE:**

**IF, BY \_\_\_\_\_, THE UFCW BENEFITS OFFICE HAS NOT RECEIVED  
EITHER:**

- 1) **A COMPLETED AUTHORIZATION FORM (authorizing the deduction from your monthly pension benefit payments of an amount equal to the monthly premium required to maintain your coverage under the plan) OR**
- 2) **A MONTHLY PREMIUM PAYMENT FOR YOUR COVERAGE UNDER THE PLAN,**

**YOU WILL BE DEEMED TO HAVE REJECTED COVERAGE UNDER THE PLAN  
AND DEFERRED SUCH COVERAGE UNTIL FIRST OF THE MONTH FOLLOWING  
YOUR 60<sup>TH</sup> BIRTHDAY, REGARDLESS OF WHETHER YOU HAVE RETURNED  
THIS FORM.**