Dependent Termination Form

Mid-America Carpenters Regional Council Health Fund (Fund)
St. Louis-Kansas City Southern Illinois Region
1419 Hampton Avenue, St. Louis, MO 63139
Phone: (314) 644-4802, option 1 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org

Complete this form to remove a dependent from health plan coverage.

SECTION 1: PARTICIPANT/DEPENDENT INFORMATION

Participant Legal Last Name	Participant Legal First Name	Participant Last 4 SSN

Dependent Legal Last Name	Dependent Legal First Name	Date of Birth	Dependent Last 4 SSN

Dependent's Relationship to the Participant:

☐ Spouse ☐ Natural Child ☐ Adopted Child ☐ Stepchild
☐ Other (explain):

Reason for removing dependent:

SECTION 2: DEPENDENT TERMINATION REQUEST

Please terminate the above-named Dependent listed above from coverage effective _____
Date (MM/DD/YYYY)

The Requested Termination Date must be the last day of a month and must be a future date. The Requested Termination Date cannot be retroactive. If you are in one of our retired or disabled monthly self-pay categories, the request to terminate at the end of the month must be received by the 15th of that month. Otherwise, coverage won't terminate until the end of the following month.

SECTION 3: AUTHORIZATION

I understand that by completing this form, the above-named Dependent will no longer be eligible for benefits under the Mid-America Carpenters Regional Council Health Plan. Should I wish to reinstate coverage for the above named Dependent, I understand supporting documentation may be required.

X _____ _____
Participant Signature **Date**

X _____ _____
Dependent Signature (if over 18) **Date**

Submit completed Dependent Termination Form:

- **Upload** securely to the Member Portal: **laborfunds.org/member-portal**
- By **mail** to the address at the top of this form, Attn: Participant Services
- By **fax** to the fax number at the top of this form