STEELWORKERS EMERGENCY MEDICAL PROGRAM

***MEMBERS WHO ARE ENROLLED IN OTHER COVERAGE ARE NOT ELIGIBLE FOR EMP COVERAGE**

WAIVER OF COVERAGE

DO NOT ENROLL ME IN THE STEELWORKERS EMERGENCY MEDICAL PROGRAM ("EMP") AT THIS TIME BECAUSE:

1. _____ I have elected COBRA from my employer
2. _____ I am enrolled under my spouse's employer-sponsored health insurance program
3. _____ I am enrolled under another employer's health insurance program
4. _____ My spouse is enrolled in this EMP and I am a covered dependent
5. _____ I am enrolled in coverage through the Marketplace (Exchange)
6. _____ I am enrolled for group insurance coverage from another source (explain):
   _____

Please identify your source of Other Coverage:

Name of Plan Sponsor _____
Carrier _____
Group Number _____

You will be eligible to enroll for EMP coverage only upon the termination of your Other Coverage identified above. In such event, you must provide your Local Union with suitable proof of termination of coverage.

Name _____
(Please print)

Local Union # 4-200 (Robert Wood Johnson) District 04

Signature _____ Date: _____

PLEASE USE THIS SIDE TO ***OPT OUT*** OF THE USW EMERGENCY MEDICAL PROGRAM