APEA-AFT Health & Welfare Trust

WAIVER OF HEALTH COVERAGE – Effective September 1, 2025

Employee Name_____Social Security No.:_____-___-____

I understand that I am eligible to enroll in health coverage through the APEA-AFT Health &Welfare Trust (Trust Plan) based on my employment status with the Juneau School District. I understand that I also have the right to waive coverage for myself, and my eligible dependents and that I cannot enroll my dependents unless I am also enrolled. I wish to opt out of coverage for the following reason (check one):

- o I have coverage through my spouse's employer
- o I have other individual coverage or I have Medicare coverage
- o I have coverage through the Coast Guard or other military plan
- o Other (please describe) _____

Attach proof of other health benefits coverage (photocopy of benefit plan or insurance ID card and eligibility date sufficient).

I hereby forfeit health coverage at this time. I fully understand that if I or my eligible dependents desire to be covered under the Trust Plan in the future, I must wait until the next Open Enrollment to elect to participate in the Trust Plan effective on the first day of the next Plan Year, or I must make a timely election of coverage as a result of and consistent with a qualified change-in-status event. I also understand that if I waive coverage currently and I elect to be covered at a later date, that I (and my eligible dependents) may have a waiting period for Pre-existing Conditions and one of the following must apply:

1. If at the time I am declining coverage, it is because:
   a) I have other group health coverage for myself and my eligible dependents, and that coverage is either terminated as a result of loss of eligibility (including loss as a result of legal separation, divorce, death, termination of employment or reduction of work hours) or employer contributions toward such coverage was terminated; or

   b) Coverage was under COBRA at the time I declined coverage and that COBRA coverage has been exhausted.

   Under a) and b) above, I must complete and submit a Trust Plan enrollment form within 31 days after I lose my current coverage.

2. If I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may enroll myself and my eligible dependents, provided that I complete and submit a Trust Plan enrollment form within 31 days of the marriage, birth, adoption or placement for adoption.

***CAUTION*:** Before waiving coverage under the Trust Plan, you should carefully evaluate your coverage needs for yourself and your eligible dependents to determine if the other coverage you have available is sufficient to protect you and your dependents in the event of an illness or injury. You are encouraged to contact your other health coverage plan to determine how waiving coverage under the Trust Plan may affect your coverage and eligibility under that plan. If you waive coverage under the Trust Plan, and you do not experience a qualifying change-in-status event that would entitle you to enroll mid-year for coverage under the Trust Plan, you must wait until the next Open Enrollment period for the Trust Plan to enroll, and coverage would then not be effective until the first day of the following Plan Year.

_____ _____

Signature Date

Scan and email to: enrollment@wpas-inc.com
Or mail to: APEA-AFT Health & Welfare, P.O. Box 34203, Seattle, WA 98124