

## 1199SEIU AETNA MEDICARE ADVANTAGE PLAN OPT-OUT FORM

To opt out of the 1199SEIU Aetna Medicare Advantage Plan, complete this form and return it by mail to 1199SEIU Benefit Funds, Retiree Health Benefits Office, 498 Seventh Avenue, New York, NY, 10018-0009; by fax to (646) 473-8799; or by email to RetireeHealth@1199Funds.org.

**I understand that by not enrolling in the 1199SEIU Aetna Medicare Advantage Plan, I will no longer be eligible for 1199SEIU Benefit Fund retiree health benefits.**

This Opt-Out Form is being provided should you choose to opt out of the 1199SEIU Aetna Medicare Advantage Plan. Please note, however, that if you choose to opt out of this program, you will give up all retiree health benefits provided by your 1199SEIU Benefit Fund, which may include prescription, Medicare Part A first-day hospital deductible, Medicare Part B reimbursement, vision, life insurance and burial.

If you are a married 1199SEIU retiree and opt out of the 1199SEIU Aetna Medicare Advantage Plan, your spouse will not be able to enroll and will lose all retiree health benefits through the Fund. However, if you join the 1199SEIU Aetna Medicare Advantage Plan, your spouse may choose to opt out separately and will not receive the Fund's retiree health benefits indicated above.

**Retiree: Please check the box and complete all information below.**

I DO NOT WISH TO ENROLL IN THE 1199SEIU AETNA MEDICARE ADVANTAGE PLAN

RETIREE'S FULL NAME		RETIREE'S SOCIAL SECURITY #	
RETIREE'S ADDRESS	CITY	STATE	ZIP CODE
RETIREE'S PRIMARY PHONE	RETIREE'S EMAIL ADDRESS		

*I have read this form and understand that by opting out of the 1199SEIU Aetna Medicare Advantage Plan, I am not entitled to 1199SEIU Benefit Fund retiree health benefits.*

**X** \_\_\_\_\_  
RETIREE'S SIGNATURE DATE (MM/DD/YYYY)

**Spouse: Please check the box and complete all information below.**

I DO NOT WISH TO ENROLL IN THE 1199SEIU AETNA MEDICARE ADVANTAGE PLAN

SPOUSE'S FULL NAME		SPOUSE'S SOCIAL SECURITY #	
RETIREE'S FULL NAME	RETIREE'S SOCIAL SECURITY #		
SPOUSE'S ADDRESS	CITY	STATE	ZIP CODE
SPOUSE'S PRIMARY PHONE	SPOUSE'S EMAIL ADDRESS		

*I have read this form and understand that by opting out of the 1199SEIU Aetna Medicare Advantage Plan, I am not entitled to 1199SEIU Benefit Fund retiree health benefits.*

**X** \_\_\_\_\_  
SPOUSE'S SIGNATURE DATE (MM/DD/YYYY)