CARPENTER FUNDS ADMINISTRATIVE OFFICE
OF NORTHERN CALIFORNIA
265 Hegenberger Road, Suite 100
Oakland, California 94621-1480
Tel. (510) 633-0333 ✧ (888) 547-2054 ✧ Fax (510) 633-0215
benefitservices@carpenterfunds.com ✧ www.carpenterfunds.com

ELECTION TO TERMINATE
DOMESTIC PARTNER HEALTH COVERAGE

Complete this form only if you want **to cancel health coverage** for your Domestic Partner and/or your Domestic Partner's dependent(s).

Effective _____ , I elect to **cancel** health coverage for:

[ ] My Domestic Partner and his or her Dependents, if any.

[ ] My Domestic Partner's Dependent(s) only. List below name(s) of Dependent(s) whose coverage should be canceled.

1st Dependent's Name: _____

2nd Dependent's Name: _____

3rd Dependent's Name: _____

I understand that my Domestic Partner will not be allowed to re-enroll for at least six months. I understand that in order for my Domestic Partner's Dependents to be eligible, my Domestic Partner must also be enrolled and eligible and appropriate Imputed Taxes paid in advance.

_____

Participant's Name (Please Print) UBC #, ID #, or Social Security Number

_____

Participant's Signature Date