Multi Union Security Trust Fund

Married Employees' Election of Joint Coverage

This is to acknowledge that we are married employees whose medical benefits are provided by the Multi Union Security Trust Fund and that we want to JOINTLY ENROLL for these benefits (medical, prescription drug, dental, options rider and vision, hereafter referred to as "Medical Benefits"). We understand that although we may jointly enroll for Medical Benefits, we must be independently enrolled for mental health and life insurance benefits.

We understand that the employee whose birthday is first in the calendar year will be the primary covered employee for Medical Benefits and the other employee will be the dependent for Medical Benefits. If the employee who is the dependent should need to enroll due to a divorce or death and continues in full time employment, the employee and eligible dependents must enroll within thirty (30) days of the date of divorce or death. If such enrollment is not done within thirty (30) days, the employee (previously enrolled as dependent) and his/her eligible dependents must wait until the next open enrollment period.

We understand that there will be no employee contribution required of the employee who enrolls as a dependent for Medical Benefits. The employee contribution will be charged to the employee who enrolls as the primary one.

However, we understand that we may not be jointly enrolled in the mental health and life insurance benefits. Therefore, the employee who is electing to enroll as a dependent (for Medical Benefits) must maintain the mental health and life insurance benefits and pay any applicable premium, if required. This election is valid **only** when both spouses sign this election form.

Election of Joint Coverage:

Initial

/_____/ I am **Electing Joint Coverage.**

Employee #1 Name (Print): _____

Date of Birth: _____ SS#: _____

Employer: _____

/_____/ I am **Electing Joint Coverage.**

Employee #2 Name (Print): _____

Date of Birth: _____ SS#: _____

Employer: _____

Executed this _____ day of _____, 200_____.

_____ _____
Signature Employee #1 Witness Signature

_____ _____
Signature Employee #2 Print Witness Name

NOTE! Please return signed original to the Administrator.

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