Local 8A-28A Welfare Fund
36-18 33rd Street, 2nd Floor
Long Island City, NY 11106

To Whom It May Concern:

Please remove my spouse and child from coverage from the Local 8A-28A Welfare Fund effective immediately. I have provided proof of their alternate health coverage.

MEMBER NAME: (PRINT) LAST	FIRST	MIDDLE	DATE OF BIRTH	SOCIAL SECURITY #.

Please enter dependents information below

NAME	DATE OF BIRTH	RELATIONSHIP	GENDER
			☐ M ☐ F
			☐ M ☐ F
			☐ M ☐ F
			☐ M ☐ F
			☐ M ☐ F

_____ _____

Member's signature Date

_____

Notary Public

_____

Date