Opt-Out Form

I_____am a participant in the USW HRA Fund ("Fund"). I understand that under federal law, I have the right to permanently forfeit and waive future reimbursements from the Fund's Health Reimbursement Arrangement ("HRA") (1) annually, by providing notice no later than December 15, to take effect January 1 of the subsequent year, or (2) within 60 days after I terminate employment.

I understand that by completing this form, I permanently forfeit, to the extent required by federal law, any balance remaining in the HRA on my behalf and that I can never get this money back. I also understand that no future contributions will be credited to the HRA on my behalf until I am reenrolled in the HRA and satisfy all applicable Plan rules to participate in the HRA. I understand that if I reenroll in HRA coverage that I will be treated as a new participant for all purposes under the HRA. I also understand that if I reenroll in HRA coverage that I will be enrolled in minimum essential coverage pursuant to Internal Revenue Code section 36B(c)(2)(C)(ii).

Please initial the line below indicating your decision to permanently forfeit your HRA balance.

_____ I hereby elect to permanently forfeit, to the extent required by federal law, and waive future reimbursements from the Fund's Health Reimbursement Arrangement.

I am completing this Form knowingly and voluntarily. I understand that this election is irrevocable.

_____ _____

Participant Name Date

_____

Signature

STATE OF _____

COUNTY OF _____

On the _____ day of_____,_____, before me personally came _____,

known to be the individual described herein and who executed the foregoing instrument, and acknowledged that she/he executed the same.

_____

Notary Public