

CENTRAL LABORERS' WELFARE FUND OPEN ENROLLMENT FORM 2011

Participant/Employee Information

Name:		
Local No.	SSN:	Home Phone:
Work Phone:	Cell Phone:	E-mail:
Current address:		
City:	State:	ZIP Code:
Date of Birth: / /	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed		

Spouse Information, if Married (Please enclose a copy of your Marriage License if not on File)

Name:		
SSN:	Home Phone:	Cell Phone:
E-mail:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Current address, if different from Participant:		
City:	State:	ZIP Code:
Employed: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time	Self Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone:
Employer Name:	Employer Address:	
City:	State:	ZIP Code:

Spouse's Other Insurance Information: (Please enclose a copy of the front and back of the cards)

Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Other/Medicare _____		
Policy Holder Name:		Effective Date:
Medical Carrier:	Group No.	ID No.
Dental Carrier:	Group No.	ID No.
Vision Carrier:	Group No.	ID No.
Prescription Carrier:	Group No.	ID No.
Other Carrier /Medicare:	Group No.	ID No.

Dependent – Adult Child – Age 19 until age 26 (Please enclose a copy of dependent's Birth Certificate if not on file)

Name:		
SSN:	Home Phone:	Cell Phone:
E-mail:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Current address, if different from Participant:		
City:	State:	ZIP Code:
Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Self Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone:
Employer Name:	Employer Address:	
City:	State:	ZIP Code:
Dependent Relationship: (i.e.-Natural Child; Step-Child; Foster Child)		

Dependent's Other Insurance Information: (Please enclose a copy of the front and back of the cards)

Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Other/Medicare _____		
Policy Holder Name:		Effective Date:
Medical Carrier:	Group No.	ID No.
Dental Carrier:	Group No.	ID No.
Vision Carrier:	Group No.	ID No.
Prescription Carrier:	Group No.	ID No.
Other Carrier /Medicare:	Group No.	ID No.

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Dependent – Adult Child – Age 19 until age 26 (Please enclose a copy of dependent’s Birth Certificate if not on File)

Name:		
SSN:	Home Phone:	Cell Phone:
E-mail:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Current address, if different from Participant:		
City:	State:	ZIP Code:
Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone:
Employer Name:	Employer Address:	
City:	State:	ZIP Code:
Dependent Relationship: (i.e.-Natural Child; Step-Child; Foster Child)		

Dependent’s Other Insurance Information: (Please enclose a copy of the front and back of the cards)

Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Other/Medicare _____		
Policy Holder Name:		Effective Date:
Medical Carrier:	Group No.	ID No.
Dental Carrier:	Group No.	ID No.
Vision Carrier:	Group No.	ID No.
Prescription Carrier:	Group No.	ID No.
Other Carrier /Medicare:	Group No.	ID No.

Dependent – Adult Child – Age 19 until age 26 (Please enclose a copy of dependent’s Birth Certificate if not on File)

Name:		
SSN:	Home Phone:	Cell Phone:
E-mail:	Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Current address, if different from Participant:		
City:	State:	ZIP Code:
Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Self-Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone:
Employer Name:	Employer Address:	
City:	State:	ZIP Code:
Dependent Relationship: (i.e.-Natural Child; Step-Child; Foster Child)		

Dependent’s Other Insurance Information: (Please enclose a copy of the front and back of the cards)

Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Other/Medicare _____		
Policy Holder Name:		Effective Date:
Medical Carrier:	Group No.	ID No.
Dental Carrier:	Group No.	ID No.
Vision Carrier:	Group No.	ID No.
Prescription Carrier:	Group No.	ID No.
Other Carrier /Medicare:	Group No.	ID No.

Dependent Children Age 0 until age 19 (Please enclose a copy of Dependent’s Birth Certificate if not on file)

Dependent Name:		Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN:	Home Phone:
Resides with Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, with whom does the child reside:	
Address, if different from Participant:		
Dependent Relationship: (i.e.-Natural Child; Step-Child; Foster Child)		
Dependent Name:		Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	SSN:	Home Phone:
Resides with Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, with whom does the child reside:	
Address, if different from Participant:		
Dependent Relationship: (i.e.-Natural Child; Step-Child; Foster Child)		

IF YOU HAVE MORE THAN 5 DEPENDENT CHILDREN 18 YEARS OF AGE OR YOUNGER, PLEASE PROVIDE THE REQUESTED FOR EACH SEPARATE PIECE OF PAPER.

Dependent Children Age 0 until age 19 (Continued)

Dependent Name: _____ Date of Birth: _____

Gender: Male Female SSN: _____ Home Phone: _____

Resides with Participant: Yes No If no, with whom does the child reside: _____

Address if different from the Participant: _____

Dependent Relationship: (i.e.-Natural Child; Step-Child; Foster Child)

Dependent Name: _____ Date of Birth: _____

Gender: Male Female SSN: _____ Home Phone: _____

Resides with Participant: Yes No If no, with whom does the child reside: _____

Address, if different from Participant: _____

Dependent Relationship: (i.e.-Natural Child; Step-Child; Foster Child)

Dependent Name: _____ Date of Birth: _____

Gender: Male Female SSN: _____ Home Phone: _____

Resides with Participant: Yes No If no, with whom does the child reside: _____

Address, if different from Participant: _____

Dependent Relationship: (i.e.-Natural Child; Step-Child; Foster Child)

Dependent Child's Other Insurance Information: (Please enclose a copy of the front and back of the cards)

Type of Coverage: Medical Dental Vision Prescription Other/Medicare _____

Policy Holder Name: _____ Effective Date: _____

Name of Dependent(s) covered by the Policies: _____

Medical Carrier: _____ Group No. _____ ID No. _____

Dental Carrier: _____ Group No. _____ ID No. _____

Vision Carrier: _____ Group No. _____ ID No. _____

Prescription Carrier: _____ Group No. _____ ID No. _____

Dependent Child's Other Insurance Information: (Please enclose a copy of the front and back of the cards)

Type of Coverage: Medical Dental Vision Prescription Other/Medicare _____

Policy Holder Name: _____ Effective Date: _____

Name of Dependent(s) covered by the Policies: _____

Medical Carrier: _____ Group No. _____ ID No. _____

Dental Carrier: _____ Group No. _____ ID No. _____

Vision Carrier: _____ Group No. _____ ID No. _____

Prescription Carrier: _____ Group No. _____ ID No. _____

DEATH BENEFIT BENEFICIARY INFORMATION

COMPLETE THE FOLLOWING SECTION IF YOU ARE A PARTICIPANT NOT COVERED BY COBRA OR RETIREE POLICY. BE SURE TO SIGN AND DATE THE BENEFICIARY ELECTION.

PRIMARY DEATH BENEFICIARY:

Beneficiary Name: _____ Relationship: _____

Beneficiary Address: _____

Beneficiary City: _____ Beneficiary State: _____ Beneficiary ZIP code: _____

ALTERNATE BENEFICIARY IF PRIMARY BENEFICIARY PRE-DECEASES ME:

Beneficiary Name: _____ Relationship: _____

Beneficiary Address: _____

Beneficiary City: _____ Beneficiary State: _____ Beneficiary ZIP code: _____

Signature of the Participant: _____ Date: _____

I WANT MY PRIMARY BENEFICIARY TO REMAIN MY PRIMARY BENEFICIARY REGARDLESS OF MARITAL STATUS. Yes No

USE MY ALTERNATE BENEFICIARY IF I AM DIVORCED FROM THE PRIMARY BENEFICIARY. Yes No

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I ELECT TO ENROLL IN THE FOLLOWING PLAN CHOICE FOR THE 2011 PLAN YEAR

Blue Cross PPO **HealthLink (Open Access Plan)** **Blue Cross HMO(Retiree Only)**

MY ENROLLMENT STATUS

Open Enrollment Active **Open Enrollment – Retiree** **Open Enrollment - COBRA**

PLEASE READ ALL THE INFORMATION BELOW CAREFULLY!

YOUR SIGNATURE ON THIS OPEN ENROLLMENT APPLICATION CONFIRMS YOU HAVE READ AND UNDERSTAND ALL OF THE INFORMATION CONTAINED WITHIN THIS FORM AND IN THE OPEN ENROLLMENT MATERIALS.

I agree that this application is subject to acceptance by the Central Laborers' Welfare Fund. I understand, that if I, and any of my dependents, are eligible to participate in the Plan, that the healthcare services available to me and/or my dependent will be subject to the exclusions, limitations, deductibles, co-payments, coinsurance and other conditions of the Summary Plan Description ("SPD") and in any amendment(s) to the SPD. I further understand that the contribution(s) necessary for me, and my dependents, to be eligible (or to maintain eligibility) under the Plan may be subject to change.

I understand that my and my dependent(s)' eligibility may be subject to verification and may require additional documentation from me including items such as marriage license, divorce decree(s), birth certificate(s), death certificate(s), Proof of Adult Child Relationship form, official documents and/or other information before I or my dependents are added and eligible on any policy offered by Central Laborers' Welfare Fund. I understand that, should I fail to submit needed verification documentation within the timeframes required, eligibility for benefits on expenses incurred by my dependents or me may be delayed in processing or denied payment until such information is provided to Central Laborers' Welfare Fund.

I certify that all the information recorded in this application is true and correct to the best of my knowledge and belief. I understand that any misrepresentation, misstatement or omission ("incorrect information") made regarding this application, whether intentional or not, will be cause for rejection of this application. In the event that this application is approved before the incorrect information is discovered, such discovery may result in termination of my coverage under the Plan or my dependant's coverage under the Plan (if such incorrect information relates to my dependents). Termination of my coverage or my dependent's coverage may be retroactive to the date of enrollment. I understand that if the terminated dependent is a minor, then I or any other responsible parent or guardian will be required to reimburse the Plan for any and all sums expended on the dependent minor's behalf for healthcare services, together with reasonable attorneys' fees and expenses incurred in collection of such sums.

I confirm that Central Laborers' Welfare Fund offered me the opportunity to enroll my dependent(s) who will be under the age of 26 years old on or after January 1, 2011. I understand I have 30 days from the date I received the dependent notice, to add those dependents. I further understand that if I do not enroll my dependent(s) during the 30 day enrollment period, the Fund Office can deny my dependent(s) coverage.

I confirm that Central Laborers' Welfare Fund informed me that my Plan will no longer have a lifetime limit on the dollar value of essential health benefits under Section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. I understand that, if I or my dependent(s) lost coverage due to having reached the Plan's lifetime limit, I have 30 days from date I received the lifetime limit notice, to reinstate coverage for me or my dependent(s) effective January 1, 2011. I affirm my understanding that if I do not enroll myself or my dependent(s) during the 30 day enrollment period, the Fund Office can deny me or my dependent(s) coverage.

I confirm that Central Laborers' Welfare Fund informed me of the Plan's grandfathered status and explained that, in being a grandfathered plan, Central Laborers' Welfare Fund can preserve certain basic health coverage that was already in effect when Patient Protection and Affordable Care Act (Affordable Care Act) was enacted. I understand that by Central Laborers' Welfare Fund being a grandfathered plan, my Plan may not include certain consumer protections of the Affordable Care Act, for example, the requirement for the provision of preventive health services without any cost sharing.

I confirm that Central Laborers' Welfare Fund provided me specific contact information where I may obtain answers to questions I may have related to grandfathered health plans and what might cause a plan to change from grandfathered health plan status. The contact information included the Central Laborers' Welfare Fund at 1-800-252-6571, the U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, and the U.S. Department of Health and Human Services at www.healthreform.gov.

I understand that, in the event of a conflict between the wording in this application, the open enrollment materials and the Plan Document that governs the Plan, the Plan Document shall govern. I further understand that the Trustees reserve the right to amend, modify and terminate the Plan at any time.

Print Name of Participant:

Signature of Participant:

Date: