

CENTRAL LABORERS' WELFARE FUND OPEN ENROLLMENT FORM 2020

Participant/Employee Information

Name:		
Local No.	SSN:	Home 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		

Participant's Other Insurance Information (THIS MAY INCLUDE COVERAGE BY A PARENT OR SPOUSE) (Coverage other than with Central Laborers' Welfare where you are the policyholder.)

(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.

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 <input type="checkbox"/> No	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: (THIS MAY INCLUDE COVERAGE BY A PARENT)

(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.

PLEASE REMEMBER:

1. INCLUDE A COPY OF YOUR MARRIAGE LICENSE/CERTIFICATE SHOWING PROOF OF LEGAL MARRIAGE IF YOU ARE ADDING A SPOUSE FOR THE FIRST TIME.
2. INCLUDE A COPY OF A BIRTH CERTIFICATE OR LEGAL DOCUMENT SHOWING PROOF OF A DEPENDENT'S RELATIONSHIP TO YOU IF YOU ARE ADDING A DEPENDENT FOR THE FIRST TIME.
3. INCLUDE A COPY OF THE CARDS FROM ANY OTHER INSURANCE COVERAGE ON YOU, YOUR SPOUSE OR DEPENDENT(S).

CONTINUE TO THE NEXT PAGE

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

THE ADULT DEPENDENT FORMS (INCLUDED IN YOUR PACKET) MUST BE COMPLETED & RETURNED ON EACH ADULT DEPENDENT

Name:		Relationship: (i.e.-Natural Child; Step-Child; Foster Child)	
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 <input type="checkbox"/> No	Self-Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone:	
Employer Name:		Employer Address:	
City:	State:	ZIP Code:	

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

THE ADULT DEPENDENT FORMS (INCLUDED IN YOUR PACKET) MUST BE COMPLETED & RETURNED ON EACH ADULT DEPENDENT

Name:		Relationship: (i.e.-Natural Child; Step-Child; Foster Child)	
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 <input type="checkbox"/> No	Self-Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No	Work Phone:	
Employer Name:			
City:	State:	ZIP Code:	

Adult 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 **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 dependent reside:		
Address, if different from Participant:			
Dependent Relationship: (i.e.-Natural Child; Stepchild; 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 dependent reside:		
Address, if different from Participant:			
Dependent Relationship: (i.e.-Natural Child; Stepchild; Foster Child)			

CONTINUE TO THE NEXT PAGE



IF YOU HAVE MORE THAN 5 DEPENDENTS 18 YEARS OF AGE OR YOUNGER, PLEASE PROVIDE THE REQUESTED INFORMATION FOR EACH ON A SEPARATE PIECE OF PAPER.

Dependent 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 Dependent reside: _____

Address if different from Participant: _____

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

Dependent Name: _____ Date of Birth: _____

Gender: Male Female SSN: _____ Home Phone: _____

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

Address, if different from Participant: _____

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

Dependent Name: _____ Date of Birth: _____

Gender: Male Female SSN: _____ Home Phone: _____

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

Address, if different from Participant: _____

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

Dependent'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'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 A RETIREE PLAN. BE SURE YOU 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: _____

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

CONTINUE TO THE NEXT PAGE



I ELECT TO ENROLL IN THE FOLLOWING PLAN CHOICE FOR THE 2020 PLAN YEAR

Blue Cross PPO

HealthLink (Open Access Plan)

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 eligibility and that of my dependent(s) 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 Dependent Relationship form, official documents and/or other information before I or my dependent(s) are added and eligible on any plan 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 dependent(s) or me may be delayed in processing, denied payment until such information is provided or denied eligibility all together by 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 that of my dependent(s) (if such incorrect information relates to my dependent(s)), and I may be required to reimburse the Plan. Termination of my coverage or that of my dependent(s) may be retroactive to the date of enrollment. I understand that if the terminated dependent(s) is/are 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(s) 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 on or after January 1, 2020 or who is an unmarried dependent over age 26 and meets the definition of a disabled dependent and whose coverage was never initiated, ended or who was denied. I understand that the opportunity to enroll such a dependent must be done within the 30 days of my Open Enrollment period if that dependent's eligibility is to begin the first day of the plan year for which I am enrolling or the effective date of my eligibility, whichever is later. I further understand that, should all the required documents needed to confirm the eligibility of my dependent(s) is not received within the 30 days of my Open Enrollment period, the eligibility effective date of my dependent(s) will be the first day of the month following receipt of my Open Enrollment form and all required documentation.

I confirm that Central Laborers' Welfare Fund informed me that my Plan has eliminated all lifetime and annual limits on the dollar value of essential health benefits under Section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations.

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.healthcare.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: