Central Laborers' Welfare Fund

P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • Fax 217/243-8619

http://www.central-laborers.com

PROOF OF ADULT DEPENDENT RELATIONSHIP FORM

BEFORE EXPENSES CAN BE CONSIDERED OR PAID ON CLAIMS INCURRED BY YOUR ADULT DEPENDENT THIS FORM AND THE EMPLOYER'S PORTION, SECTION 2, MUST BE COMPLETED, SIGNED AND RETURNED TO THE FUND OFFICE FOR PROCESSING. THE EMPLOYER'S FORM MAY BE RETURNED SEPARATELY OR MAY BE MAILED DIRECT BY YOUR ADULT DEPENDENT'S EMPLOYER.

If you are enrolling an adult dependent, (age 19 until age 26), you must complete the following information to confirm his/her eligibility for coverage.

SECTION 1

(If you answer Yes to Section 1, you must complete Section 2.)

_____ is employed: ☐ **Yes** ☐ **No**
(Adult Dependent Name)

☐ **I have completed the "Adult Dependent Insurance Coverage Information" form and forwarded that document to my adult dependent's employer. I will ensure a copy of that completed document is forwarded to Central Laborers' Welfare Fund. I understand that until the Fund Office receives this information, no claims can be processed for payment. I also understand that if the form is not received timely, claims may remain denied.**

_____ _____
(Participant's Signature) (Date)

_____
ID#

Central Laborers' Welfare Fund

P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • Fax 217/243-8619

http://www.central-laborers.com

Section 2

CENTRAL LABORERS' WELFARE FUND ADULT DEPENDENT INSURANCE COVERAGE INFORMATION

THE PARTICIPANT'S AND ADULT DEPENDENT'S SIGNATURE IS REQUIRED ON THE LOWER PORTION OF THIS FORM BEFORE FORWARDING TO THE ADULT DEPENDENT'S EMPLOYER.

INFORMATION ON ADULT DEPENDENT'S EMPLOYER SPONSORED INSURANCE COVERAGE

(This section is to be completed by the employer)

Your Employee's Name: _____

Is employee eligible for your employer-sponsored group health insurance plan? ☐ **Yes** ☐ **No**

If yes, please note the coverage: ☐ **Health** ☐ **Prescription** ☐ **Dental** ☐ **Vision**

If no, will this employee be eligible for employer-sponsored group health insurance in the future? ☐ **Yes** ☐ **No**

If yes, on what date will your employee be eligible for employer-sponsored group health insurance? _____
Month/Day/Year

Your Employee's Hire Date _____
Month/Day/Year

Employer's Name or Business: _____

Completed By: _____
Employer's Signature **Date**

_____ **Phone #** _____
Please print Name and Title

THE PARTICIPANT'S AND ADULT DEPENDENT'S SIGNATURE ARE REQUIRED BELOW BEFORE FORWARDING TO THE ADULT DEPENDENT'S EMPLOYER.

Authorization to Release Information: I hereby authorize my employer to release the information requested above to Central Laborers' Welfare Fund for the sole purpose of ascertaining eligibility for enrollment in my employer-sponsored plan.

_____
Adult Dependent's Signature **Date**

Participant's Certification: I certify that the above information has been completed by my adult dependent's employer. I understand that it is my responsibility to notify the Fund of any changes. I understand that if my adult dependent is eligible to participate in his or her employment-based health coverage and declines such coverage, then Central Laborers' Welfare Fund Plan will pay only 20% of any otherwise allowable charges.

_____
Participant Signature **ID#** **Date**