

# CENTRAL LABORERS' WELFARE FUND ENROLLMENT/ADD/UPDATE FORM 2021

## 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		

## 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"/> Medicare <input type="checkbox"/> Other: _____		
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 COVERING YOU, YOUR SPOUSE OR DEPENDENT(S).

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 (ENCLOSED) MUST BE COMPLETED & RETURNED ON EACH ADULT DEPENDENT YOU ENROLL**

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"/> Medicare	<input type="checkbox"/> Other: _____
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 the 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; 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 dependent reside:	
Address, if different from Participant:		
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"/> Medicare	<input type="checkbox"/> Other: _____
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.			
Other Carrier /Medicare:	Group No.		ID No.			

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

**READ THE FOLLOWING INFORMATION CAREFULLY AND THEN SIGN AND DATE THIS FORM IN THE SPACE PROVIDED ON THE NEXT PAGE.**

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 my dependent's coverage under the Plan (if such incorrect information relates to my dependents), and I may be required to reimburse the Plan. 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 my dependent(s) who is/are under the age of 26 years, or who is/are an unmarried dependent over age 26, but who meets the definition of a disabled dependent, meet the requirement(s) for special enrollment and has experienced a qualifying event. I understand that the opportunity to enroll such a dependent must be completed, including providing required documentation, within 30 days of the qualifying event or, if enrolling a dependent due to birth, within 90 days of the dependent(s) date of birth. If enrollment or submission of any required documentation is delayed beyond a 30-day period from the qualifying event, 90 days if adding a dependent due to birth, then the eligibility effective date of my dependent(s) will be the first day of the month following receipt of this Enrollment/Add/Update 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](http://www.dol.gov/ebsa/healthreform), and the U.S. Department of Health and Human Services at [www.healthcare.gov](http://www.healthcare.gov).

I understand that, in the event of a conflict between the wording in this application, the 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:**

**PLEASE SEE THE LIST OF DOCUMENTS ON THE FOLLOWING PAGE,  
WHICH MAY BE REQUIRED BY THE FUND IN ORDER TO CONFIRM A DEPENDENT'S  
ELIGIBILITY. IF ANY OF THE LISTED CIRCUMSTANCES PERTAIN TO YOUR  
PERSONAL SITUATION, PLEASE PROVIDE COPIES OF  
THE INFORMATION REQUESTED.**

SITUATION	REQUIRED DOCUMENTS
BIOLOGICAL DEPENDENT (PARENTS MARRIED) (ANY AGE)	COPY OF THE DEPENDENT'S BIRTH CERTIFICATE
BIOLOGICAL DEPENDENT (PARENTS NEVER MARRIED) (ANY AGE)	COPY OF THE DEPENDENT'S BIRTH CERTIFICATE AND A VOLUNTARY ACKNOWLEDGMENT OF PATERNITY OR LEGAL DOCUMENT SHOWING PARTICIPANT'S RESPONSIBILITY TO COVER
LEGALLY ADOPTED OR PENDING ADOPTION (ANY AGE)	COPY OF ADOPTION PAPERS OR SWORN STATEMENT WITH DATE OF PLACEMENT
STEP-CHILD (ANY AGE) OR BIOLOGICAL CHILD (PARENTS NOW DIVORCED)	COPY OF NATURAL PARENT'S DIVORCE DECREE MUST BE A FILED COPY AND INCLUDE INFORMATION REGARDING HEALTHCARE BENEFIT RESPONSIBILITY
DEPENDENT PLACED UNDER FOSTER CARE OR UNDER LEGAL GUARDIANSHIP (ANY AGE)	COPY OF DOCUMENT PLACING THE DEPENDENT IN THE PARTICIPANT'S HOME FOR FOSTER CARE OR LEGAL GUARDIANSHIP DOCUMENTS
ADULT DEPENDENT (AGE 19-26) (NOT DISABLED) (THIS DOCUMENTATION IS REQUIRED ANNUALLY.)	ADULT DEPENDENT RELATIONSHIP FORMS (IF EMPLOYED, THE EMPLOYER MUST COMPLETE THEIR PORTION.)
ADULT DEPENDENT (DISABLED)	A DEPENDENT CONFIRMATION FORM AND A STATEMENT, FROM A LICENSED PHYSICIAN OR A COURT DOCUMENT CONFIRMING THE DEPENDENT'S INCAPACITY
SPOUSE	COPY OF THE MARRIAGE CERTIFICATE AND YOUR SPOUSE'S OTHER INSURANCE CARDS (IF YOUR SPOUSE IS EMPLOYED FULL TIME AND INSURANCE IS OFFERED THROUGH THAT EMPLOYMENT, YOUR SPOUSE IS REQUIRED TO ENROLL IN THE EMPLOYER'S COMPARABLE PLAN.)
REMOVING SPOUSE, DEPENDENT/STEP-CHILDREN DUE TO DIVORCE OR LEGAL SEPARATION	FILED COPY OF THE DIVORCE DECREE OR LEGAL SEPARATION PAPERS
TERMINATING SPOUSE OR DEPENDENT COVERAGE DUE TO DEATH	COPY OF THE DEATH CERTIFICATE