CENTRAL LABORERS' WELFARE FUND
ENROLLMENT/ADD/UPDATE FORM 2022

Participant/Employee Information

Name:		
Local No.	SSN:	Home Phone:
Cell Phone:		E-mail:
Current address:		
City:	State:	ZIP Code:
Date of Birth:	Gender: ☐ Male ☐ Female	
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ 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: ☐ Male ☐ Female
Current address, if different from Participant:		
City:	State:	ZIP Code:
Employed: ☐ Full Time ☐ Part Time ☐ No	Self Employed: ☐ Yes ☐ 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: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ 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 COVERING YOU, YOUR SPOUSE OR DEPENDENT(S).**

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

Name:	Relationship: (i.e.-Natural Child; Step-Child; Foster Child)	
SSN:	Home Phone:	Cell Phone:
E-mail:	Date of Birth:	Gender: ☐ Male ☐ Female
Current address, if different from Participant:		
City:	State:	ZIP Code:
Employed: ☐ Full Time ☐ Part Time ☐ No	Self-Employed: ☐ Yes ☐ 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: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ 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: ☐ Male ☐ Female	SSN:	Home Phone:
Resides with Participant: ☐ Yes ☐ No	If no, with whom does the dependent reside:	
Current 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 dependent reside:	
Current 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: ☐ 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.

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), 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 (Fund) informed me that it believes it is a "grandfathered health plan" under the Patient Protections and Affordable Care Act (the Act) and, as permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Fund may not include certain consumer protections of the Act that apply to other plans, for example, the requirements for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. I understand the Fund will notify me when certain other consumer protections are adopted.

I confirm that Central Laborers' Welfare Fund provided me specific contact information where I may obtain answers to questions regarding which protections apply to a grandfathered health plan 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 Employee Benefits Security Administration, the U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This web site has a table summarizing which protections do and do not apply to grandfathered health plans.

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 (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

QUESTIONS?
PLEASE CALL 1-800-252-6571, OPTION 5