



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#



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Section 2

CENTRAL LABORERS' WELFARE FUND ADULT DEPENDENT INSURANCE COVERAGE INFORMATION

**THE PARTICIPANT'S AND ADULT DEPENDENT'S SIGNATURE ARE 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

Please print Name and Title Phone # _____

**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