

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

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:

(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 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).

Dependent – Adult Child – Age 19 until age 26 (Please enclose a copy of dependent's Birth Certificate 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:
Dependent Relationship: (i.e.-Natural Child; Step-Child; Foster Child)				

Adult Child'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 Children 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 child reside:

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 child reside:

Address, if different from Participant:

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

Dependent Child'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 THAN 2 DEPENDENTS THAT YOU WANT TO ADD TO YOUR PLAN, 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 and my dependent(s)' eligibility 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 Child Relationship form, official documents and/or other information before I or my dependents are added and eligible on any policy 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 dependents or me may be delayed in processing or denied payment until such information is provided to 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 dependant's coverage under the Plan (if such incorrect information relates to my dependents). 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 Central Laborers' Welfare Fund offered me the opportunity to enroll my dependent(s) who will be under the age of 26 years old on or after January 1, 2012. I understand I have 30 days from the date I received the dependent notice, to add those dependents. I further understand that if I do not enroll my dependent(s) during the 30 day enrollment period, the Fund Office can deny my dependent(s) coverage.

I confirm that Central Laborers' Welfare Fund informed me that my Plan has eliminated all lifetime limits on the dollar value of essential health benefits under Section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations. In addition, I confirm that Central Laborers' Welfare Fund has informed me that the Fund applied for and was approved for a Waiver of Restricted Annual Limits in 2011 and that Waiver approved and extended through Plan Year 2013. I have received a notice that explained what the Waiver of Restricted Annual Limits is and how it will affect the Benefits I am currently eligible or may be eligible to receive in Plan Year 2012.

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:

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.

DEPENDENTS AGE BIRTH TO 19 YEARS OLD	Must include one or more of the following:
Biological Child (Parents Married)	Copy of child's birth certificate
Biological Child (Parents Never Married)	Copy of child's birth certificate and Voluntary Acknowledgement of Paternity or legal document showing a responsibility to cover the child.
Biological Child (Parents Divorced)	Copy of child's birth certificate and the first and last page of the divorce decree, stamped by the court, along with the page showing the custodial parent and who is responsible for the child's insurance coverage.
Legally adopted or pending adoption	Copy of adoption papers or sworn statement with date of placement.
Child placed under legal guardianship	Copy of guardianship papers.
Child placed under foster care	Copy of document placing the child in the Participant's home for foster care.
Step-child	Copy of the child's natural parent's first and last page of the divorce decree, stamped by the court, along with the page showing the custodial parent and who is responsible for the child's insurance coverage.
ADULT CHILDREN AGE 19-26	Copy of child's birth certificate and other documents as noted above.
Adult Child (Not handicapped)	If employed, complete your portion of the Adult Child Insurance Coverage Information form after which your Adult Child's employer must complete their portion and return the form to the Fund Office.
Unmarried dependent (handicapped)	Documents outlined above, a Handicapped Dependent Confirmation Form and providing proof of incapacity including the date the handicap began.
OTHER CIRCUMSTANCES	
Spouse	Copy of marriage certificate and a copy of your spouse's primary insurance card if he/she works full-time and is offered insurance coverage through his/her employer. (See Summary Plan Description for more information on the type of coverage that Full Time working spouses must maintain.)
Removing ex-spouse, dependent/step-children due to divorce or legal separation.	Copy of the first and last page of the divorce decree or filed legal separation papers stamped by the court.
Deleting spouse or dependent coverage due to death	Copy of the death certificate.
If you have any questions regarding dependent coverage, please call the Fund Office at: 1-800-252-6571 ext 120	