



## Central Laborers' Pension, Welfare & Annuity Funds

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

<http://www.central-laborers.com>

### PROOF OF ADULT CHILD RELATIONSHIP FORM

**If you are enrolling an adult child, (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 Child Name)

I have completed the "Adult Child Insurance Coverage Information" form and forwarded that document to my adult child's employer. I will ensure a copy of that completed document is forwarded to Central Laborers' Welfare Fund. If the Fund Office does not receive this information, I understand my adult child will not be eligible for benefits.

\_\_\_\_\_  
(Participant's Signature)

\_\_\_\_\_  
(Date)



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## Section 2

### CENTRAL LABORERS' WELFARE FUND ADULT CHILD INSURANCE COVERAGE INFORMATION

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

#### INFORMATION ON ADULT CHILD'S EMPLOYER SPONSORED INSURANCE COVERAGE

**(This section is to be completed by the adult child's 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

Completed By: \_\_\_\_\_  
Employer's Signature Date

\_\_\_\_\_  
Please print Name and Title

**THE PARTICIPANT'S AND ADULT CHILD'S SIGNATURE ARE REQUIRED BELOW BEFORE FORWARDING TO THE ADULT CHILD'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 Child's Signature Date

Participant's Certification: I certify that the above information has been completed by my adult child's employer. I understand that it is my responsibility to notify the Fund of any changes. I understand that if my adult child is eligible to participate in his or her employer-sponsored group health insurance plan, that adult child will not be eligible for coverage in the Central Laborers' Welfare Fund Plan.

\_\_\_\_\_  
Participant Signature ID# Date