CENTRAL LABORERS' WELFARE FUND OPEN ENROLLMENT FORM 2024

Partici	nant/	Fmn	OVEE	Information

	rticipant/Emp					
	ame:			Harra Dhanar		
	ocal No. SSN:		Home Phone:			
Cell Phone:						
Current address:	-					
City:	State:			ZIP Code:		
Date of Birth:	Gender:					
	arried	Divorced	Legally Se	•		
Participant's Other Insurance Inf (Coverage other than with C						
(Please enclos	e a copy of th	e front and ba	ck of the ca	rds.)		
Type of Coverage: Medical Dent	al 🗌 Vision	Prescription	Medica	re 🗌 Other		
Policy Holder Name:			Effective Date	e:		
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.			
Spouse Information, if Married (Ple	ase enclose a	copy of your l	Marriage Lic	ense if not on file.)		
Name:						
SSN:	Home Phone:		Cell Phone:			
E-mail:			Gender:			
Current address, if different from Participar	nt:					
Employed: 🗌 Full Time 🗌 Part Time 🗌] No Self Em	ployed: 🗌 Yes	🗌 No 🛛 W	ork Phone:		
Employer Name:	Emp	oyer address:				
City:	State:		ZIP Code:			
Spouse's Other Insurance Information: (THIS MAY INCLUDE COVERAGE BY A PARENT)						
(Please enclos	e a copy of th	e front and ba	ck of the ca	rds.)		
Type of Coverage: 🗌 Medical 🗌 Der	ntal 🗌 Vision	Prescripti	on 🗌 Med	icare 🗌 Other		
Policy Holder Name:			Effective Date	e:		
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 COVERAGE ON YOU, YOUR SPOUSE						
OR DEPENDENT(S).						
	CONTINUE TO	THE NEXT PAG	E			

Adult Dependent – Age 19 until age 26 (Please enclose a copy of the dependent's Birth Certificate if not on file.)					
Name:	Relationship: (i.eNatural Ch				
SSN:	Home Phone:	Cell Phone:			
E-mail:					
Current address, if different from Participant:					
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 Inform	nation: (Please enclose a copy of	the front and back of the cards.)			
	Vision Prescription 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.			
Adult Dependent – age 19 until age 26 (Ple	ase enclose a copy of the depend	ent's Birth Certificate if not on file.)			
Name:	Relationship: (i.eNatural Ch	ild; Step-Child; Foster Child)			
SSN:	Home Phone:	Cell Phone:			
E-mail:	Date of Birth:	Gender:			
Current address, if different from Participant:					
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 Inform	nation: (Please enclose a copy of	the front and back of the cards.)			
	Vision Prescription 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 <mark>age 0 until age 19</mark> (Please enclo	se a copy of the dependent's Birt	h Certificate if not on file.)			
Dependent Name:	Date of Birth:				
Gender:	SSN:	Home Phone:			
Resides with Participant: Yes No					
Current address, if different from Participant:					
Dependent Relationship: (i.eNatural Child; Stepchild; Foster Child)					
Dependent Name:	Date of Birth:				
Gender:	SSN: Home Phone:				
esides with Participant: Yes No If no, with whom does the dependent reside:					
Current address, if different from Participant:					
Dependent Relationship: (i.eNatural Child; Stepchild; Foster Child)					
CONTINUE TO THE NEXT PAGE					

Dependent age 0 until age 19 (Continued)				
Dependent Name:	Date of Birth:				
Gender:	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.eNatural Child; Stepchild	; Foster Child)				
Dependent Name:		Date of Birth:			
Gender:	SSN:		Home Phone:		
Resides with Participant: Yes No	If no, with w	hom does the dependent reside	2:		
Current address, if different from Participant:					
Dependent Relationship: (i.eNatural Child; Stepchild	; Foster Child)	1			
Dependent Name:	Date of Birth:				
Gender:	SSN:		Home Phone:		
Resides with Participant: Yes No	If no, with w	hom does the dependent reside	2:		
Current address, if different from Participant:					
Dependent Relationship: (i.eNatural Child; Stepchild					
Dependent's Other Insurance Information	: (Please er	close a copy of the front	and back of the cards.)		
Type of Coverage: Medical Dental	Vision	Prescription 🗌 Medicare [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.		
Dependent's Other Insurance Information	-				
	Vision 🗌 I	Prescription 🗌 Medicare [Other		
Policy Holder Name:			Effective Date:		
Name of dependent(s) covered by the Policies:	Curry No.				
Medical Carrier:	Group No.		ID No.		
Dental Carrier:	Group No.		ID No.		
Vision Carrier:	Group No.		ID No.		
· ·	scription Carrier: Group No. ID No. YOU HAVE MORE DEPENDENTS, PLEASE PROVIDE THE REQUESTED INFORMATION FOR EACH ON A SEPARATE PI				
IF TOU HAVE MORE DEPENDENTS, PLEASI	PROVIDE	OF PAPER.	ATION FOR EACH ON A SEPARATE PIECE		
DEATH BENEFIT BENEFICIARY INFORMATION					
COMPLETE THE FOLLOWING SECTION IF YOU ARE A PARTICIPANT NOT COVERED BY COBRA OR A RETIREE PLAN. BE SURE YOU SIGN AND DATE THE BENEFICIARY ELECTION.					
PRIMARY DEATH BENEFICIARY:					
Beneficiary Name:	Relation		iship:		
Beneficiary Address:		I	•		
Beneficiary City:	Beneficiary S	State:	Beneficiary ZIP code:		
ALTERNATE BENEFICIARY IF PRIMARY BENEFICIARY PRE-DECEASES ME:					
Beneficiary Name: Relationship:					
Beneficiary Address:		L			
Beneficiary City:	Beneficiary State:		Beneficiary ZIP code:		
Signature of the Participant:	the Participant:		Date:		
USE MY ALTERNATE BENEFICIARY IF I AM DIVORCED FROM THE PRIMARY BENEFICIARY.					
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Blue Cross PPO Healthlink (Open Access Plan) W FUNCTUALINET STATUS Copen Enrollment Active Open Enrollment - Retiree Open Enrollment Active Degree that this explication is subject to acceptance by the Critical Lobors? Welfare Fund. Indextons, Bulcation is subject to acceptance by the Critical Lobors? Welfare Fund. Initiations, deutations, deutations, on subject to acceptance by the Critical Lobors? Welfare Fund. Indextons, Bulcation is subject to acceptance by the Critical Lobors? Welfare Fund. Initiations, deutations, deutations, on excessary for me, and my dependents, to be eliptice (or to maintain eligibility) under the Plan involves by be subject to dring. Initiations, deutations, deutations, deutations, device derivers), birth criticates(), deutation exceptes Fund. Indextsand that my elipibility and that of my dependent(s) may be subject to verification accuments and/or orbit information before I or my dependent(s) are added and elipible on amplication is the mediance required, dipiblity of breating on equires and diverse by device by Central Loborers? Including them subject in orbits application is true and correct to the best of my incovidegia and belief. I Londerstand that my elipibility the human interfames required (s) (sub information recorded in mission ("incorrect information") made regarding this application, which the true mission ("incorrect information") and regarding this application, which the true mission ("incorrect information") is application which the true mission ("incorrect information") and regarding this application which the true advices in the application is application is the earth that adplication is applicati	I ELECT TO ENROLL IN THE FOLLOWING NETWORK FOR THE 2024 PLAN YEAR					
Open Enrollment Active Open Enrollment – Retire Open Enrollment - COBRA RAD THE FOLLOWING INFORMATION CAREFULLY AND THEN SIGN AND DATE THIS FORM IN THE SPACE PROVIDED RAD THE FOLLOWING INFORMATION CAREFULLY AND THEN SIGN AND DATE THIS FORM IN THE SPACE PROVIDED Target that this application is subject to acceptance by the Cartral Laborers? Waffer Fund. 1 Lunderstand, that 1, 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 company. Inducting them schemes, diverce derivers? Waffer Fund. 1 Lunderstand that, should 1 fail to subject to drange. Inductand that my eligibility and that of my dependent(s) may be subject to verification and may require additional documents and/or other information before 1 or my dependent(s) are added and eligible on any plan offered by Central Laborers? Weffare Fund. 1 Lunderstand that, should 1 fail to submit needed verification documentiation within the timeframes required, digibility for benefits on expresses incured by my dependent(s) or me my be delayed in processing, denied payment until such information is provided or denied eligibility all together by Central Laborers? Weffare Fund. Inderstand that any mistergenentiation measure that this application is the used correct lifermation? Interface addet and eligibility to benefits on expresses addet addet of enrollment. Investign thermination encoded in this application is approved before the incorrect information is discovered, add the cause for rejection of this application. In the event that any mistergenentific shift, and any weight addet of enrollment. Investign thermination encoded in this application is approved before the incorrect information in the addet of enrollment. Investign that the terminated dependent(s) in any other percepticity(s) and in any expression ("Sincer any other responsion"). Investign the subject to reinitize additional documents and the ad	BI			Plan)		
READ THE FOLLOWING INFORMATION CAREFULLY AND THEN SIGN AND DATE THIS FORM IN THE SPACE PROVIDED I agree that this application is subject to acceptance by the Central Laborers' Weffare Fund. I understand, that I I, and any of my dependents, are eligible to participate in the Plan, that the healthcare services available to me and/or my dependent, to be available to the and/or the nay amendment (5) to the STD. Turther understand that the contribution(s) necessary for me, and wide pendents, to be eligible to the maintain eligiblity) under the Plan my be subject to change. Understand that my eligiblity and that of my dependent(s) may be subject to verification and may require additional documentation from me including terms such as marriage license, divorce decree(s), third certificate(s), detait certificate(s), official documents and/or other information before I or my dependent(s) are added and eligible on any plan ofference? Welfare Fund. I understand that avoid I fail to submit needed verification documentation within the timeframes required, eligiblity for benefits on expenses incurred by my dependent(s) or me my be dayad in processing, denied payment until such information is provided or denied eligiblity all together by Central Labores? 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 misserpresentation, instatement or omission ("incorrect information") made regarding his application, whether intentional or net, will be cause misserpresentation, instatement or omission ("incorrect information") made regarding his application, whether intentional or net, will be cause misserpresentation, instatement or omission ("incorrect information") made regarding his application, whether intentional or net, will be cause misserpresentation, misstatement or omission ("incorrect information") made regarding his application, whether intentional or net, will be readed on the dependent(s) is/are a minor, then I or any	Open Enrollment Active			- CORPA		
I agree that this application is subject to acceptance by the Central Laborers' Welfare Fund. I understand, that I fL and any of my dependents, are eligible to price that the number of the subject to the exclusions, limitations, deductibles, co-psyments, consurance and other conditions of the Summary Plan Description ("SPD") and in any amendment(s) to the SPD. Further understand that the contribution(s) necessary for me, and my dependents, to be eligible (or to maintain eligiblity) 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), diffield documents and/or other information before 1 or my dependent(s) are added and eligible on any plan offered by Central Laborers' Welfare Fund. I understand that, should I fail to subject to verification and may require additional documentation within the information is provide or denied eligibility all together by Central Laborers' Welfare Fund. Lestify that all the information recorded in this application is proved dor denied eligibility all together by Central Laborers' Welfare Fund. I may be required to reinbore ("incorrect information is approved hydrow hether internional or nu, will be cause for rejection of this application. In the event that this application is approved hydrow hether internional or nu, will be cause in the subject to any other regooned sub, discovery may result in termination of my coverage or that of my dependent(s) may be theraced sub of dependent(s) involved and mainter internional or nu, will be cause into my dependent(s) may be theraced sub of dependent(s) involved and welfare. The application is approved hydrow and the incorrect information is discovered, such discovery may result intermination of my coverage or that of my dependent(s) may be theraced such and welface coverage. In any other regoons in any other regoons in preventity to r						
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 anonement(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 documents and/or other information before the endedmain eligibility and that of my dependent(s) death certificate(s), death certificate(s), death certificate(s), death certificate(s), death certificate(s), death certificate(s), official documents and/or other information before the endedmain eligibility and that of my dependent(s) may be subject to verification and may require additional discover may may be deayed in processing, denied payment until such information is provided or denied eligibility all together by Central Laborers' Weffare Fund. Lerdify 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 intertiniation of my coverage or that of my dependent(s) (if such incorrect information relates to the deated eligibility may be required to reinburse the Plan. Termination or my coverage or that of my dependent(s) inhore restorable to the deated or eligibility of the required to reinburse. The Plan Termination of my coverage undertake the plan to any and ther centeration is discovered my results interminated dependent(s) kiras a minor, then I car any other responsible parent or guardian will be required to reinburse the Plan to any and alian see equired to the dependent(s) inhore the related to reinburse the relation of my dependent(s) in						
including terms such as marriage license, divorce decree(s), birth certificate(s), death certificate(s), official documents and/or other information 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 Labores' Weffare 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 interhional or not, will be cause for rejection of this application. In the event that this application is approved before the incorrect information relates to my dependent(s) (s), and 1 may be required to reimburse the Plan. Termination of my coverage or that of my dependent(s) (may be retractive to the date of enrollment. I understand that dependent(s) (s)/size 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(s) 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 on or after January 1, 2024 or who is an unmarried dependent exponsible parent for unstate dependent responsible parent or sub thin the 31 days of my Open Enrollment fpend, the eligibility with comendation of a disabled dependent so of such sums. 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 of any Open Enrollment fpend, the eligibility with central caborers' Welfare Fund (hund) informed me that they of the plan year	are eligible to participate in the Plan, the limitations, deductibles, co-payments, SPD. I further understand that the contract of the second	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				
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 that of my dependent(s) if such incorrect information is discovered, such discovery may result in termination of my coverage under the Plan or that of my dependent(s) may be required to reimburse the Plan for any and all sums sequended on the dependent(s) 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 on or after January 1, 2024 or who is an ummaried dependent over age 26 and meets the definition of a disabled dependent and whose coverage was never initiated, ended or who was denied. I understand that the opportunity to enroll such a dependent must be done within the 31 days of my Open Enrollment period if that dependent's eligibility is to begin the first day of the plan year for which 1 am enrolling or the effective date of my dependent(s) is in tree-eviewed within the 31 days of my Open Enrollment period, the digibility whicher is later. I further understand that, should all the required documents toto. 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 (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 was exacted. Being agrandfathered health plan can preserve certain basic health coverage that was already in effect when that law was exacted. Being agrandfathered health	including items such as marriage licens before I or my dependent(s) are added submit needed verification documental may be delayed in processing, denied	se, divorce decree(s), birth certific d and eligible on any plan offered tion within the timeframes require	ate(s), death certificate(s), official do by Central Laborers' Welfare Fund. I d, eligibility for benefits on expenses	cuments and/or other information understand that, should I fail to incurred by my dependent(s) or me		
after January 1, 2024 or who is an unmarried dependent over age 26 and meets the definition of a disabled dependent and whose coverage was never initiated, ended or who was denied. I understand that the opportunity to enroll such a dependent must be done within the 31 days of my Open Enrollment period if that dependent's eligibility is to begin the first day of the plan year for which I am enrolling or the effective date of my eligibility, whichever is later. I further understand that, should all the required documents needed to confirm the eligibility of my dependent(s) is not received within the 31 days of my Open Enrollment 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 plan and what might cause a plan to change from grandfathered health plan status. The contact information included the 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 (or musel or my sole and to not apply to grandfathered heal	misrepresentation, misstatement or on for rejection of this application. In the result in termination of my coverage up may be required to reimburse the Plan understand that if the terminated depe- the Plan for any and all sums expended	hission ("incorrect information") m event that this application is app nder the Plan or that of my depen . Termination of my coverage or endent(s) is/are a minor, then I or d on the dependent(s) minor's be	ade regarding this application, wheth roved before the incorrect information dent(s) (if such incorrect information that of my dependent(s) may be retr any other responsible parent or guar	her intentional or not, will be cause in is discovered, such discovery may relates to my dependent(s)), and I oactive to the date of enrollment. I rdian will be required to reimburse		
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 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 <u>www.dol.gov/ebsa/healthreform</u> . This web site has a table summarizing which protections do and do not apply to grandfathered health plans. I confirm that I understand I can elect to cease coverage for Vision and/or Dental Benefits under the Welfare Fund for myself or my dependents even though such Benefits are provided at no additional cost to me. I also understand that, to cease either of these coverages. I will need to provide written notice to the Fund Office of my intention to cease coverage. Cessation of vision or dental coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you. I also confirm that I understand that if I previously elected to cease coverage for Vision and/or Dental Benefits und	after January 1, 2024 or who is an unmarried dependent over age 26 and meets the definition of a disabled dependent and whose coverage was never initiated, ended or who was denied. I understand that the opportunity to enroll such a dependent must be done within the 31 days of my Open Enrollment period if that dependent's eligibility is to begin the first day of the plan year for which I am enrolling or the effective date of my eligibility, whichever is later. I further understand that, should all the required documents needed to confirm the eligibility of my dependent(s) is not received within the 31 days of my Open Enrollment period, the eligibility effective date of my dependent(s) will be the first day of the month					
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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 <u>www.dol.gov/ebsa/healthreform</u> . This web site has a table summarizing which protections do and do not apply to grandfathered health plans. I confirm that I understand I can elect to cease coverage for Vision and/or Dental Benefits under the Welfare Fund for myself or my dependents even though such Benefits are provided at no additional cost to me. I also understand that, to cease either of these coverages, I will need to provide written notice to the Fund Office of my intention to cease coverage. Cessation of vision or dental coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you. I also confirm that I understand that if I previously elected to cease coverage for Vision and/or Dental Benefits under the Welfare Fund, I may reinstate coverage by providing written notice to the Fund Office. I further understand that reinstatement of vision or dental coverage will be effective as of the first day of the month immediately following the date the Fund Office receives such written notice from you. 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:	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					
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Signature of Participant: Date:	-					
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