SUPPLEMENTAL COVERAGE

ENROLLMENT FORM

THIS FORM MUST BE COMPLETED BY **ALL WELFARE FUND MEMBERS WHO WISH TO ENROLL A NEW ELIGIBLE SPOUSE OR DEPENDENT IN SUPPLEMENTAL DENTAL COVERAGE**. FORMS MUST BE RECEIVED BY THE WELFARE FUND MANAGER BY **SEPTEMBER 28, 2020.** FAILURE TO COMPLETE AND RETURN THIS FORM **WITH THE APPROPRIATE DOCUMENTATION** WILL RESULT IN OUR INABILITY TO PROCESS AND PROVIDE COVERAGE.

Member Information:			
Last Name		First Name	Middle Initial (MI)
Mailing Address			Social Security #
City		State	Zip code
Gender: ☐ F ☐ M	Date of Birth (Month/Day/Year)	Daytime Phone Number ( )	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Date of Hire:		Building or Shop:	

Enrollment: Please list any eligible family members you would like to obtain coverage for

		Last Name, First Name and Middle Initial	Sex	DOB	SS#	Lives with Member? Yes/No*	Has Other Coverage? Yes/No**
	□Spouse □Domestic Partner						
	Child						
	Child						
	Child						
	Child						
	Child						

* If no, please provide alternate address of dependent:

_____

**Please name other coverage:

_____

THE FOLLOWING DOCUMENTATION IS REQUIRED FOR A:

SPOUSE: COPY OF MARRIAGE CERTIFICATE

DOMESTIC PARTNER: COPY OF DOMESTIC PARTNER AFFIDAVIT AND PROOF OF FINANCIAL INTERDEPENDENCE

SON OR DAUGHTER: COPY OF BIRTH CERTIFICATE

STEPCHILD: COPY OF BIRTH CERTIFICATE AND YOUR MARRIAGE CERTIFICATE TO THE CHILD'S PARENT

DOMESTIC PARTNER'S CHILD: COPY OF BIRTH CERTIFICATE AND YOUR DOMESTIC PARTNER AFFIDAVIT AND DECLARATION OF FINANCIAL INTERDEPENDENCE

LEGALLY ADOPTED CHILD OR CHILD PLACED FOR ADOPTION: COPY OF COURT ORDER PAPERS SIGNED BY THE JUDGE

FOSTER CHILD: COPY OF DOCUMENTATION FROM AN AUTHORIZED PLACEMENT AGENCY, JUDGMENT, DECREE OR OTHER COURT ORDER

DISABLED CHILD AGE 26 OR OLDER WHO IS PERMANENTLY AND TOTALLY DISABLED: COPY OF 1st TWO PAGES OF TAX RETURN AND PROOF OF DISABILITY

CHILD UNDER LEGAL GUARDIANSHIP WITH PARTICIPANT: COPY OF COURT ORDER AND BIRTH CERTIFICATE

HIPAA Special Enrollment Rights Under the Plan

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage). However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing towards the other coverage)and before March 31st. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption and before March 31st..

You and your dependents may also enroll in this plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you or your dependents lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends. You and your dependents may also enroll in this plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance and before March 31st. Contact the Fund Office for further information.

The Affordable Care Act requires that you have the option to waive your medical reimbursement account benefit. If you would like to waive or opt-out of your medical reimbursement account benefit, please contact the Fund Office.

ALL INFORMATION (INCLUDING SOCIAL SECURITY NUMBERS AND APPROPRIATE DOCUMENTATION OF RELATIONSHIP TO MEMBER) MUST BE RECEIVED BEFORE COVERAGE CAN BE ACTIVATED. DIVORCED SPOUSES ARE NOT ELIGIBLE FOR COVERAGE AND MEMBERS MAY BE HELD ACCOUNTABLE FOR ANY CLAIMS FILED BY A DIVORCED SPOUSE.

BY SIGNING THIS ENROLLMENT FORM, YOU ARE ACKNOWLEDGING THAT YOU UNDERSTAND:

1. **FUNDS WILL BE DEDUCTED FROM YOUR PAYCHECKS DURING THE MONTHS OF OCTOBER THROUGH JUNE**
2. **THIS IS AN OPT-OUT PLAN. FUNDS WILL BE DEDUCTED EVERY YEAR UNTIL YOU NOTIFY THE FUND OFFICE*, IN WRITING*, OF ANY ADDITIONS OR DELETIONS.**

_____ _____

EMPLOYEE SIGNATURE **DATE**