IRONWORKERS LOCAL 11

BENEFIT FUNDS & TRAINING FACILITY

BUILT ON TRUST, FOUNDED ON SERVICE

To: All Active and COBRA Participants of the Iron Workers Local 11 Welfare Fund

Date: May 1, 2023

Re: Re-Enrollment Form for Adult Dependent Children Ages 19 to 26

Effective July 1st, 2023, an Adult Dependent Child is eligible for coverage under the Plan even if such adult child is eligible for coverage under another employer-sponsored health plan other than a group health plan of a parent.

Under the terms of the Plan, for Adult Dependent Children (ages 19 to 26) to be covered, the Fund must receive a completed Re-Enrollment Form each year. If you have an adult dependent child currently covered under the Plan, please complete the Re-Enrollment Form on the reverse side for the **July 1st 2023 – June 30th, 2024 Enrollment Period**, and **return it to the Fund Office by June 30, 2023**.

INSTRUCTIONS FOR COMPLETING THE RE-ENROLLMENT FORM FOR ADULT DEPENDENT CHILDREN - AGES 19 TO 26

You must complete this form for all adult dependent children who are between the ages of 19 and 26, who are **currently** enrolled in the Plan. If your child is **not** currently enrolled in the plan, you must submit a **notarized copy** of the child's birth certificate and photocopy of his/her social security card with the completed form.

You must complete a separate form for each adult dependent child you wish to re-enroll in the Plan. You (the Participant) must complete the form in its entirety and you and your adult dependent child (any dependent adult children ages 19 to 26) must sign and date the form.

Please note:

- If you have more than one child whom you wish to re-enroll, you will need to complete a separate form for each adult dependent child. Additional forms are available on our website, www.ironnj.com.
- You must complete this form for each adult dependent child(ren) (those dependent children who are ages 19 to 26) who is/are currently covered under the Plan.
- You must complete the attached form and **return it to the Fund Office by June 30, 2023**.
- If the Fund Office does not receive the necessary paperwork by the deadline, coverage will be suspended for the child as of **July 1, 2023** until the Fund Office receives the re-enrollment material.
- If the Fund Office receives the completed paperwork after the deadline, coverage will be provided as of the first of the month of the date the form is received.
- **Dependents who will be turning 26 are covered until the end of the month of their 26th birthday.**
- Completed forms should be returned promptly to:

Iron Workers Local 11 Welfare Fund
12 Edison Place
Springfield, NJ 07081

IRON WORKERS LOCAL 11 WELFARE FUND ANNUAL RE-ENROLLMENT FORM FOR ELIGIBLE ADULT DEPENDENT CHILDREN AGES 19 TO 26

(Complete one form for each Adult Dependent Child)

A. 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)	Home Phone Number	Cell Phone Number
B. Dependent Enrollment: Dependent's relationship to you: ☐ Son/Daughter ☐ Adopted Child ☐ Child placed with you for adoption			
Dependent's Last Name		First Name	Middle Initial (MI)
Gender ☐ F ☐ M	Date of Birth: (Month/Day/Year)	Dependent's Social Security #:	

Is your adult dependent (age 19 to 26) : • Currently enrolled in the Plan: ☐ Yes ☐ No • Married? ☐Yes ☐ No • Employed? ☐ Yes (complete Section C) ☐ No • Is dependent's spouse employed? ☐ Yes ☐ No If yes, complete Section C	Is your adult dependent ***Eligible for*** **<u>other</u>** employer-sponsored coverage, if answering yes to any of these, complete Section D: • through his/her own employer? ☐ Yes ☐ No • through his/her spouse's employer? ☐ Yes ☐ No • through his/her other parent's employer? ☐ Yes ☐ No

C. Employer Name/Address and Phone number: If your dependent is employed, provide employer name, address, and phone number. If the dependent is married and the spouse is employed, provide information about the spouse's employer.	
Adult Dependent's Employer Name:	
Employer Address and Phone & Fax Number:	
Adult Dependent's Spouse's Name:	
Spouse's Employer Name:	
Employer Address and Phone & Fax Number:	

D. Eligibility for Other Health Care Coverage: Complete the following section if your adult dependent is currently ***eligible for*** health coverage through his/her own employment, another parent's employment, or his/her spouse's employment, even if not enrolled in coverage.			
Policyholder's Name:	Policyholder relationship to Dependent: ☐Parent ☐Self ☐Dependent's Spouse	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:	Address:		Phone #:

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I authorize the Fund Office to contact my employer to verify the existence of other coverage that may be available to me through that employment. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my eligibility for Plan coverage will be terminated retroactively and I and my parent will be liable for any claims that were paid erroneously based on the false or misleading information.

Member Signature_____ Date_____

Adult Dependent Signature_____ Date_____