

SPECIAL ENROLLMENT FORM FOR CHILD OF A PARTICIPANT

➔ YOU MUST SIGN WHERE INDICATED ON THE OTHER SIDE OF THIS FORM.

I. INFORMATION ABOUT PARTICIPANT

1. Full name _____
2. SSN or Indiv. ID# _____
3. Address _____

II. INFORMATION ABOUT CHILD

1. Full name of child _____
2. Child's SSN _____
3. Child's date of birth including year _____
4. Child's relationship to you _____ (natural, adopted, etc.)
Documentation of child's relationship is required—See Section V on page 2 of this notice
5. Sex: M F
6. Child's address if different than yours _____
7. Is child employed? If so, give name, address and TELEPHONE NUMBER of employer _____

8. Is child eligible for health care coverage through his or her employment? yes no
9. Is child married? yes no If 'yes,' complete Section III.

III. INFORMATION ABOUT CHILD'S SPOUSE (Skip if child is unmarried)

1. Full name of child's spouse _____
2. Child's spouse's SSN _____
3. Date of child's marriage to spouse _____
4. Is child's spouse employed? If so, give name, address and TELEPHONE NUMBER of employer _____

5. Is child eligible for health care coverage through his or her spouse's employment? yes no

(over)

IV. SIGNATURE

I wish to add the child listed above to my coverage through the Local 734 Welfare Fund. I affirm that if this child is age 19-25 he or she is not eligible to enroll in the plan if he or she is eligible for any health care coverage offered through the child's employment or the child's spouse's employment, and that if he or she becomes eligible for such coverage in the future, I will inform the Fund within 30 days. I further affirm that the information given on this form is true and correct to the best of my ability.

READ BEFORE SIGNING

THE FUND'S RIGHT TO PROTECT ITSELF FROM FRAUD: A child age 19 or older who is eligible for coverage through his or her employment or through his or her (the child's) spouse's employment is **NOT ELIGIBLE** for coverage under Fund—even if the other plan has high premiums. A person who withholds information about other available coverage from the Fund is committing fraud, and the Fund has the right to take legal action against him or her and to cancel coverage retroactively for the child as well as the employee signing this form and any other covered dependents.



Employee's Signature

Date

V. SUBMIT TO FUND OFFICE WITH DOCUMENTATION. After you have completed and signed this form, mail it to the Fund Office at the address shown at the top of the form.

If this child has never been covered under the Fund, you must include a certified copy of the child's birth certificate. If the child was not born of your current marriage, you must submit copies of all pertinent court orders (divorce decrees, custody awards, paternity orders, etc.). You do **NOT** have to submit these documents if the child was previously covered under the Fund but lost coverage when he or she reached the age limit.