IATSE LOCAL 22
WELFARE FUND

Managed for the Trustees by: TIC MIDWEST

HEALTH CARE ENROLLMENT FORM AND
YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

Participant's Name | Birthdate | SSN/Member ID | Telephone number

Address:

MARITAL STATUS (Check One): ☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **Widow** ☐ **Separated**

Spouse's Name | Birthdate | Social Security No.

Dependent's Name | Relationship | Birthdate | Social Security No.

FAMILY CONTINUATION COVERAGE

-NOTE: PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN 19-26 ON THE REVERSE SIDE OF THIS FORM-

Are you or your dependents covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.
Check One ☐ Yes ☐ No If Yes, please complete the section below:
Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance | Telephone number

Address of Other Insurance | Effective Date of Coverage

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy

Are you or your dependents covered by any other dental insurance?
Check One ☐ Yes ☐ No If Yes, please complete the section below:
Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance | Telephone number

Address of Other Insurance | Effective Date of Coverage

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy

Are you or your dependents covered by any other vision insurance?
Check One ☐ Yes ☐ No If Yes, please complete the section below:
Is this policy (Check One) ☐ Group ☐ Individual

Name of Other Insurance | Telephone number

Address of Other Insurance | Effective Date of Coverage

Policy Number | Group Number | Policyholder's Name

Family Members Covered under the Policy

PLEASE READ CAREFULLY AND SIGN BELOW

I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, Medical claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

Member's Signature: **Date:**

Spouse's Signature: **Date:**

Return this form to: IATSE LOCAL 22 WELFARE FUND, 6525 Centurion Drive, Lansing MI 48917
ADULT CHILD UNDER AGE 26 FOR WHICH THE EXTENSION OF COVERAGE IS REQUESTED
(If you have more than two dependents for which you would like to reinstate coverage, please use a separate sheet of paper. See Back.)

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend dependent child coverage up to age 26. Dependents qualify whether they are married or unmarried. However, if your dependent has another offer of employer-based coverage (such as through his or her job) they are not eligible to enroll under this Plan.

NAME OF ADULT CHILD _____ **SOCIAL SECURITY NUMBER** _____

COMPLETE ADDRESS OF ADULT CHILD _____ **BIRTH DATE** _____

FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is your adult child eligible to enroll in employer-based coverage? ☐ Yes ☐ No

If yes, is your adult child enrolled in employer-based coverage? ☐ Yes ☐ No

If Yes, please complete the section below:

Effective date of other medical insurance:_____ Is this policy (check one) ☐ Group ☐ Individual

Name of Other Insurance Telephone number

Address of Other Insurance

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy

NAME OF ADULT CHILD _____ **SOCIAL SECURITY NUMBER** _____

COMPLETE ADDRESS OF ADULT CHILD _____ **BIRTH DATE** _____

FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Check One ☐ Yes ☐ No If Yes, please complete the section below:

Is your adult child eligible to enroll in employer-based coverage? ☐ Yes ☐ No

If yes, is your adult child enrolled in employer-based coverage? ☐ Yes ☐ No

If Yes, please complete the section below:

Effective date of other medical insurance:_____ Is this policy (check one) ☐ Group ☐ Individual

Name of Other Insurance Telephone number

Address of Other Insurance

Policy Number Group Number Policyholder's Name

Family Members Covered under the Policy

PLEASE READ CAREFULLY AND SIGN BELOW

I have read the information describing the special enrollment opportunity for adult children and understand the participation conditions and requirements. By signing below, I certify that: 1) the information provided above is correct; 2) All adult child coverage is contingent upon me maintaining my eligibility under the Plan; 3) I will be financially responsible for any claims paid for ineligible adult children if the claims were paid based on inaccurate or misleading information I provide. I understand that if I intentionally falsify any of the above information, medical claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

Member's Signature: _____ **Date:** _____

Spouse's Signature: _____ **Date:** _____