EWTF

Electrical Welfare Trust Fund

10003 Derekwood Lane, Suite 130 ♦ Lanham, MD ♦ 20706-4811 ♦ Phone 301-731-1050 1-800-929-3983 ♦ FAX 301-731-1065

Enrollment Form – Adult Child under Age 26

Effective January 1, 2011, pursuant to the Patient Protection and Affordable Care Act, the EWTF is modifying the criteria for adult children to be eligible for coverage under the EWTF. Children age 19 to 26 will now be eligible for health coverage. Eligible adult children that enroll during the special election period of November 15, 2010 through December 15, 2010, will receive coverage beginning on January 1, 2011. Eligible adult children that enroll after the special election period will receive coverage that begins on the first of the month following the date of enrollment.

The EWTF does not provide coverage for the spouse of an adult child. The EWTF does not provide coverage for the child of an adult child.

This Enrollment Form must be completed and signed by both the Participant and the Adult Dependent. Submit one Enrollment Form for each adult child.

This information is to be completed by the person working under the jurisdiction of Local 26, IBEW, as well as by their adult child under age 26. You are required to notify the Fund Office of any changes in your address, marital status, dependent information or other insurance information. Both you and your adult child are required to notify the Fund Office of any change in the adult child's address, marital status, or eligibility for other employer-sponsored health coverage.

Is this a new address, telephone number or email address? ☐ YES ☐ NO

Part I (Participant Information)

Participant's Last Name	First Name	Middle Initial
Street Address	**City & State**	**Zip+4**
Phone Number (Include area code) Home Cell	**Email Address**	
Social Security Number	**Date of Birth**	**Gender** Male Female

Part II (Adult Dependent Information)

Full Name of Adult Dependent (Last, First, Middle Initial)	Social Security Number	Relationship to Participant (son, daughter, stepson, stepdaughter)	Date of Birth (attach copy of birth certificate)

The back of this form refers to other insurance coverage for the adult dependent child. If the back of this form is not signed and dated it is incomplete. If you do not answer the questions on the back of this form, your adult dependent child will not be added. You will be notified by mail of what you need to do to complete the process.

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Other Insurance Including Medicare Information

Adult dependent **must** answer each question on this page.

1. If you are employed, are you eligible for health coverage through your employer? YES NO (If Yes, attach a copy of the front and the back of the insurance card)

2. Are you eligible for health coverage through your spouse's employer? YES NO (If Yes, attach a copy of the front and the back of the insurance card)

3. Do you have Medicare coverage? YES NO (If Yes, attach a copy of the front of the card)

4. Are you enrolled in any other health coverage? (For instance, if you have dependent coverage through another parent)? YES NO

    a. (If Yes, provide details)

5. Will you be enrolling in any other health coverage (For instance, if you are eligible for dependent coverage through another parent)? YES NO

    a. (If Yes, provide details)

Participant Signature (person working under Local 26 jurisdiction)

I hereby certify that my dependent meets all of the requirements for eligibility as an adult dependent/child as described and on this form. I further certify that the information furnished to the EWTF is accurate and complete and that I am jointly responsible (along with my dependent) for immediately notifying the EWTF of any changes in the status or address of my dependent, including their eligibility to enroll in another employer-sponsored health plan. I understand that I am jointly responsible for benefits paid based upon the information furnished and that benefits paid by the EWTF based on incorrect information may result in the loss of future benefits and will require repayment of benefits.

Signature _____ Date_____

Adult Dependent Signature

I hereby certify that I meet all of the requirements for eligibility as an adult dependent/child as described on this form. I further certify that the information furnished to the EWTF is accurate and complete and that I am responsible for immediately notifying the EWTF of any changes, including my eligibility to enroll in another employer-sponsored health plan. I understand that I am jointly responsible for benefits paid based upon the information furnished and that benefits paid by the EWTF based on incorrect information may result in the loss of future benefits and will require repayment of benefits.

Signature _____ Date_____