ENROLLMENT FORM FOR ELIGIBLE ADULT CHILDREN UNDER 26

YOU MUST COMPLETE A SEPARATE FORM FOR EACH ADULT CHILD YOU WANT TO COVER OR CONTINUE TO COVER UNDER THE LOCAL 580 INSURANCE FUND

ENROLLMENT FORM FOR ADULT CHILDREN

Enclosed is the new adult child enrollment form. This enrollment form applies to all adult children ages 19-26 whom you wish to enroll in or continue to be covered under the Local 580 Insurance Fund. College letters, bills etc. are no longer needed to extend the health care eligibility. Enrollment of your adult child will be requested by the Fund Office annually. Feel free to make copies of these forms or contact the Fund Office at (212) 695-5206 for additional forms

It is important that you return these completed forms as soon as possible.

INSTRUCTIONS

1. Complete this form for each of your adult children that you wish to be, or continue to be, covered under the plan.
2. If you have more than one child, you will need to complete a separate form for each adult child. The Local 580 Insurance Fund defines adult children as any child covered under the Plan who has reached his or her 19th birthday.

REGARDLESS OF WHETHER OR NOT YOUR CHILD IS CURRENTLY COVERED UNDER THE PLAN, YOU MUST COMPLETE THIS FORM FOR ALL ADULT CHILDREN OVER THE AGE OF 19. YOU MUST COMPLETE THE FORM IN ITS ENTIRETY, SIGN IT, AND DATE IT IN ORDER FOR IT TO BE ACCEPTED BY THE FUND OFFICE. PLEASE PRINT OR TYPE ALL INFORMATION LEGIBLY.

Coverage will not be effective until the first of the month after the month in which the Fund Office receives the completed enrollment material. In addition, no claims will be paid for the periods during which the adult child was not properly enrolled.

If the adult child is not currently enrolled in the Plan, you must provide a copy of the child's original birth certificate with the member listed as the natural father. For adopted children or those placed for adoption, a copy of the adoption paperwork is needed in order for your adult child to be enrolled in the Plan. For step-children, you must provide a copy of your and your spouse's marriage certificate, adult child's birth certificate, social security number as well as your prior three years tax returns.
All documents must be clearly legible and translated to the English language if necessary.

* IT IS IMPERATIVE THAT YOU INFORM US OF ANY CHANGES TO THE STATUS OF YOUR ADULT CHILD'S EMPLOYMENT OR HEALTHCARE STATUS. IF FRAUD IS DETECTED ALL ELIGIBILTY WILL BE LOST.

ENROLLMENT FORM FOR ELIGIBLE ADULT CHILDREN UNDER AGE 26

YOU MUST COMPLETE A SEPARATE FORM FOR EACH ADULT CHILD YOU WANT TO COVER OR CONTINUE TO COVER UNDER THE LOCAL 580 INSURANCE FUND

A. Member Information:

Last Name	First Name	Middle Initial (MI)

Mailing Address	Social Security #

City	State	Zip code / Apt#

Gender ☐ F ☐ M	Date of Birth (Month/Day/Year)	Email Address	Home Phone number	Cell/Phone Number

B. Adult Child Enrollment: Child's relationship to you: ☐ Natural Son/Daughter ☐ Adopted Child ☐ Child placed with you for adoption ☐ Stepchild

Last Name	First Name	MI	Sex	DOB	SS#
			☐ F ☐ M		

Is adult child currently enrolled in the Plan? ☐ Yes ☐ No Is child married? ☐ Yes ☐ No
Is adult child employed ☐ Yes ☐ No Is child's spouse employed? ☐ Yes ☐ No (if yes, complete C)
Does your adult child have other health care coverage:
through his/her employer ☐ Yes ☐ N through his/her spouse's employer ☐ Yes ☐ N (if yes, complete D) ____Other

C. Employer Name/Address and Phone number: If you answer yes and your child is employed, provide employer name, address and phone number. If the child is married and spouse is working, provide information on employer for working spouse.

Adult Child's Employer Name:_____

Employer Address and Phone number: _____

Adult Child's Spouse's Employer Name:_____

Employer Address and Phone number: _____

D. Other Health Care Coverage Information: Complete the following section if your child(ren) is ***currently*** covered under other group health coverage either through his/her own employment or his/her own spouse's employment.

Policyholder's Name:	Policyholder relationship to Child ☐ Self ☐ Child's spouse	Policyholder DOB:	Group and Policy #:

Insurance Company/Claims Administrator Name:	Address:	Phone #:

Member Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my child's eligibility for Plan coverage will be terminated retroactively and I will be liable for any claims that were paid erroneously based on the false or misleading information.
Signature (Member)_____ Date_____

Adult Child's Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I authorize the Plan 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. Signature (Adult Child)_____ Date_____

Adult Child's Spouse's Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I authorize the Plan Office to contact my employer to verify the existence of other coverage that may be available to my spouse through my 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 my spouse and his/her parent will be liable for any claims that were paid erroneously based on the false or misleading information. Signature (Adult Child Spouse)_____
Date_____