Stone and Marble Masons of the Washington, D.C. Area Health and Welfare Fund

ENROLLMENT FORM – ADULT CHILD UNDER AGE 26

Effective February 1, 2011, pursuant to the Patient Protection and Affordable Care Act, the Fund is modifying the criteria for adult children to be eligible for coverage under the Fund. Children age 19 to 26 will now be eligible for health coverage. Eligible adult children that enroll during the special election period of January 1, 2010 through February 15, 2011, will receive coverage beginning on February 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 Fund does not provide coverage for the spouse of an adult child. The Fund does not provide coverage for the child of an adult child. Prior to February 1, 2014, adult children who are eligible for health coverage in an employer-sponsored plan that is not a parent's plan cannot be added.

This Enrollment Form must be completed and signed by both the Participant and the Adult Dependent(s).

Name of Participant

Last Name	First Name	MI
Address		
City	State	Zip Code
Telephone	Email Address	
Participant's Social Security Number (SSN):		
Marital Status (Please Circle) Married Single Widowed Divorced Separated Date of Marriage		

I hereby apply for participation for my dependent(s) in the Stone and Marble Masons of the Washington, D.C. Area Health and Welfare Fund. I and my dependent(s) agree to follow the rules and regulations determined by the Board of Trustees as communicated to me through the Stone and Marble Masons of the Washington, D.C. Area Health and Welfare Fund Summary Plan Description or updates thereto.

I hereby certify that my dependent(s) meets all of the requirements for eligibility as an adult dependent/child as described in the attached letter and on this form. Specifically, I certify that my adult dependent/child is not eligible to enroll in an employer-sponsored health plan through their own employment, or through the employment of their spouse. I further certify that the information furnished to the Fund is accurate and complete and that I am jointly responsible (along with my dependent) for immediately notifying the Fund 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 provision of false information to the Fund Office, or failure to update the Fund Office that a child has become eligible for an employer-sponsored plan, will result in retroactive loss of eligibility. I also understand that I am jointly responsible for benefits paid based upon the information furnished and that benefits paid by the Fund based on incorrect information may result in the loss of future benefits and will require repayment of benefits.

I certify that I have carefully read both sides of this enrollment form and agree to the terms specified. The foregoing statements are complete, true, and correctly recorded.

Participant's Signature (DO NOT Print)_____ Date_____

MAIL COMPLETED FORM TO:

Stone and Marble Masons of the Washington, D.C. Area Health and Welfare Fund
7130 Columbia Gateway Drive, Suite A
Columbia, MD 21046

PLEASE READ BOTH SIDES OF FORM CAREFULLY

LIST BELOW THE NAME(S) OF YOUR CHILDREN BETWEEN THE AGES OF 19 AND 26 YEARS OF AGE FOR WHOM YOU DESIRE COVERAGE.

A COPY OF THE BIRTH CERTIFICATE (OR OTHER PROOF OF DEPENDENT STATUS) MUST BE INCLUDED WITH THIS APPLICATION FOR ANYONE WHO WAS NEVER PREVIOUSLY ENROLLED.

EACH PERSON MUST COMPLETE THE FOLLOWING.

WRITE "N/A" IN ANY FIELD THAT DOES NOT APPLY.

FORMS WITH INCOMPLETE FIELDS WILL BE RETURNED, WHICH MAY RESULT IN A DELAY OF COVERAGE THROUGH THIS FUND.

LIST NAMES IN ORDER OF AGE – ELDEST FIRST	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	IF YOU ARE EMPLOYED, ARE YOU ELIGIBLE FOR HEALTH COVERAGE THROUGH YOUR EMPLOYER? YES OR NO	ARE YOU ELIGIBLE FOR HEALTH COVERAGE THROUGH A SPOUSE'S EMPLOYER? YES OR NO	DO YOU HAVE MEDICARE COVERAGE? YES OR NO (If yes, attach a copy of the front of the card)	ARE YOU CURRENTLY ENROLLED OR WILL BE ENROLLING IN ANOTHER PARENT'S PLAN? YES OR NO (If yes, please attach the information)

Adult Dependent #1 Signature

I hereby certify that I meet all of the requirements for eligibility as an adult dependent/child as described in the attached letter and on this form. **Specifically, I certify that I am not eligible to enroll in an employer-sponsored health plan through my employment or through my spouse's employment. I further certify that the information furnished to the Fund is accurate and complete and that I am responsible for immediately notifying the Fund of any changes, including my eligibility to enroll in another employer-sponsored health plan**. I understand that provision of false information to the Fund Office, or failure to update the Fund Office that I have become eligible for an employer-sponsored plan, will result in retroactive loss of eligibility. I understand that I am jointly responsible for benefits paid based upon the information furnished and that benefits paid by the Fund based on incorrect information may result in the loss of future benefits and will require repayment of benefits.

Signature _____ **Date**_____

Adult Dependent #2 Signature

I hereby certify that I meet all of the requirements for eligibility as an adult dependent/child as described in the attached letter and on this form. **Specifically, I certify that I am not eligible to enroll in an employer-sponsored health plan through my employment or through my spouse's employment. I further certify that the information furnished to the Fund is accurate and complete and that I am responsible for immediately notifying the Fund of any changes, including my eligibility to enroll in another employer-sponsored health plan**. I understand that provision of false information to the Fund Office, or failure to update the Fund Office that I have become eligible for an employer-sponsored plan, will result in retroactive loss of eligibility. I understand that I am jointly responsible for benefits paid based upon the information furnished and that benefits paid by the Fund based on incorrect information may result in the loss of future benefits and will require repayment of benefits.

Signature _____ **Date**_____