TEAMSTERS LOCAL 922 – EMPLOYERS HEALTH TRUST
DEPENDENT ENROLLMENT FORM

BASIC INFORMATION

Member's Name: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

_____

Telephone No. _____

Active or Retired? _____ Date of Retirement: _____

Medicare Eligible? _____

DEPENDENT ELIGIBILITY

Are you seeking coverage under the Teamsters Local 922 – Employers Health Trust for any child *OVER* the age of 18? ☐ **Yes** ☐ **No**

IF YES, YOU MUST COMPLETE ALL APPLICABLE SECTIONS OF THIS FORM:

For each child you are seeking to have covered as a Dependent, provide the following information:

Child 1: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

_____ Employed: ☐ Yes* ☐ No

*Employer: _____ Phone #: _____

Child 2: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

_____ Employed: ☐ Yes* ☐ No

*Employer: _____ Phone #: _____

(Add additional pages if necessary)

YOU MUST ATTACH A COPY OF EACH CHILD'S BIRTH CERTIFICATE OR PROOF OF LEGAL GUARDIANSHIP.

(over)

EFFECTIVE OCTOBER 1, 2010, FOR THE PURPOSES OF THIS FUND, THE TERM CHILD IS DEFINED AS:

The natural or legally adopted child or a child placed for adoption, stepchild or a child under guardianship. To be eligible, the child must be under the age of 26.

A child who, upon reaching age 26 and who is physically or mentally incapable of self support will continue to be considered a child for as long as the incapacity continues provided proof of such incapacity is provided to the Fund Office and that the child became incapacitated prior to age 21.

Children who are ***ELIGIBLE,*** whether or not enrolled, for coverage through his/her employer are **NOT** eligible dependents under this Fund.

MEMBER CERTIFICATION

I hereby certify that:

_____ (Initial Here) I will notify the Fund's Plan Administrator in a timely manner if or when any of my dependents over the age of 18 becomes eligible to participate in his/her own employer-sponsored health care plan, and I understand that such notification will thereby forfeit such dependent's right to continue coverage under the Plan as my Dependent.

_____ (Initial Here) The information contained in this Form is true and correct and I understand that the Trustees are relying on this information and the representations I have made in this Form to provide my Dependent(s) with coverage under the Plan.

_____ (Initial Here) If I fail to submit this completed form annually or as otherwise required by the Fund, I understand that my Dependent's eligibility for benefits may be terminated.

_____
Signature of Member

Date: _____