*Abatement Workers Local 207 Health and Welfare Fund*
*Adult Child Dependent Form*
*Participant Information*

| | |
|---|---|
| **NAME:** | **Last 4 digits of SS #:** |
| **STREET ADDRESS:** | **HOME PHONE #:** |
| **CITY, STATE, ZIP:** | **DATE OF BIRTH:** |

**Children whose coverage ended, or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26 are now eligible to enroll in the Health and Welfare Fund. Participants may request enrollment for such children for the next 30 days from the date you receive this notice by completing the bottom of this form. Enrollment will be effective June 1, 2011. For more information, contact the Fund Office at 800. 772.0459.**

The participant **must certify** that the adult child being enrolled meets **ALL** of the following criteria (please check the boxes to certify agreement):

☐ **The Adult Child was previously removed from coverage, or not eligible for coverage, due to age restrictions; AND**

☐ **The Adult Child is currently under 26 years of age; AND**

☐ **The Adult Child is not currently eligible to enroll under his/her employer-sponsored health plan**
**Name of Employer _____; AND**

☐ **If the Adult Child is married, the Adult Child is not currently eligible to enroll under his/her spouse's employer-sponsored health plan.**
**Name of Employer _____**

THE HEALTH AND WELFARE FUND'S COVERAGE OF AN ADULT CHILD WILL AUTOMATICALLY END ON THE LAST DAY OF THE MONTH IN WHICH THAT ADULT CHILD TURNS 26 YEARS OLD.

**EFFECTIVE DATE FOR THE ADULT CHILD'S COVERAGE WILL BE JUNE 1, 2011**

***Complete this section to enroll Adult Child for coverage (if applicable). Below is for any Adult Child previously enrolled in the Plan and coverage was terminated. If you need to enroll an Adult Child that has never been added to the plan, we will also need a vital form filled out, which you can obtain by contacting the Fund Office for a vital form to be sent to you.***

| | Circle Relationship | Adult Child's Name | Birth Date | Last four digits of Social Security # |
|---|---|---|---|---|
| **ADD** | Son / Daughter | | | |
| **ADD** | Son / Daughter | | | |
| **ADD** | Son / Daughter | | | |

I have read the information describing the special enrollment opportunity 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 as defined by the Plan Document; **3)** I will be financially responsible for any claims paid for ineligible adult children if the claims were paid based upon inaccurate or misleading information I have provided above.

Participant's Signature _____ Date_____

**Please return this form to: Abatement Workers Local 207 Health and Welfare Fund**
**P.O. BOX 1349**
**Troy, Michigan 48099-1349**

**THIS SPECIAL ENROLLMENT FORM MUST BE RECEIVED BY THE FUND OFFICE BY MAY 15, 2011**