IBEW LOCAL 234 HEALTH AND WELFARE PLAN

October 2026 Alt ID: 1234567890

SECOND REQUEST

MEMBER NAME
ADDRESS
ADDRESS

Important - Dependent Audit Verification

Enclosed form is required to be completed and submitted
to the Administrative Office by **November 30, 2026**

Dear Participant,

As a commitment to control healthcare costs, the IBEW Local 234 Health and Welfare Plan ("the Plan") is taking steps to ensure that only eligible dependents are covered under the Plan. In order to accomplish this, the Plan is conducting a Dependent Audit Verification and all participants are required to participate.

Included with this notice is a Dependent Audit Verification form that must be completed by you. Once complete, you can submit the form to the Administrative Office using the enclosed return envelope by **November 30, 2026**.

If you fail to return the Dependent Audit Verification form by November 30, 2026, your dependents will be removed from coverage until the form is returned to the Trust Fund office and eligibility is confirmed.

Additionally, if you knowingly submit false information this will be deemed an act constituting fraud or an intentional misrepresentation of material fact. The Plan may seek to recover all claims during the period that the ineligible dependent was covered.

If you have any questions about this Dependent Audit Verification, please contact the Trust Fund Office at (408) 588-3753.

Sincerely,

Board of Trustees

6293 San Ignacio Ave • San Jose, CA 95119 • P.O. Box 670 • San Jose, CA 95109
Phone 408-588-3753 • Toll Free 877-885-3753 • Fax 408-436-8210
www.ibew234benefits.org • staff@ibew234benefits.org

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October 2026 Alt ID: 1234567890

MEMBER NAME
ADDRESS
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DEPENDENT AUDIT 2026 – VERIFICATION FORM

You are **REQUIRED** to check the boxes for each dependent below, complete and submit this form to the Administrative Office by **November 30, 2026**

According to our records, the following Dependent(s) are currently enrolled on your health plan:

Dependents that **do not meet** the definition of an Eligible Dependent **will be removed from the IBEW Local 234 Health and Welfare Plan as soon as administratively possible** (*examples of eligible dependents are*: your legal spouse, your children/stepchildren/adopted children from birth up to the end of the month in which they turn 26), and children whom you have been appointed as a legal guardian. The definition and Plan provisions for dependent eligibility are on the back of this form.

Enrolled Dependent Name	Social Security Number already on file? **If blank, please provide Social Security Number**	Does this person meet the definition of an Eligible Dependent?		If Dependent is no longer eligible, please indicate the date of ineligibility.
		YES	**NO**	
DEPENDENT NAME	**XXX-XX-******	☐	☐	
DEPENDENT NAME	**XXX-XX-******	☐	☐	
DEPENDENT NAME	**XXX-XX-******	☐	☐	
DEPENDENT NAME	**XXX-XX-******	☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	
		☐	☐	

FOR INELIGIBLE DEPENDENTS: If any Dependent listed above is **no longer eligible**, please attach a statement explaining why the Dependent is ineligible. If it is due to other insurance coverage, please provide a copy of the Dependent's insurance card. In the case of divorce, adoption, or termination of parental rights or guardianship, please attach a copy of any relevant court paperwork.

If you need to **ADD** a Dependent, please complete the enclosed enrollment form and provide all required legal documentation (Birth Certificate(s) for children, Marriage Certificate for spouse, Legal Adoption Papers, Guardianship Court Order naming you as the legal guardian) to the Administrative Office.

By my signature on this form, I certify and warrant to the Plan that all information on this form is true, correct, and current as of the date signed. I understand that the Plan is relying on my answers provided for this process. I represent, under penalty of perjury, that the answers given to all questions on this form are true and accurate. I understand that if I knowingly and with intent to defraud the Plan, provide any materially false information or conceal, for the purpose of misleading, information concerning any fact material thereto, I may be subject to ineligibility, offset of benefits, recovery, civil and criminal penalties.

Signature of Participant: _____ **Date:** _____

Who is an eligible Dependent? Dependents of an Employee become eligible for coverage on the same date as the Employee, or if acquired later, on the date the Dependent first becomes an eligible Dependent. The term "Dependent(s)" means a lawful spouse and the Participant's children up to the end of the month in which a child attains age 26.

1. LAWFUL SPOUSE

An eligible Dependent includes the Participant's lawful spouse (including opposite-sex and same-sex spouses) who is not legally separated from the spouse in any form. California law and this Plan do not recognize a common law marriage.

2. CHILDREN THROUGH 25 YEARS OF AGE

A Participant's Dependent Child(ren) through age 25 who meets all other Plan requirements is eligible to enroll and be maintained as a Dependent regardless of whether the Dependent Child(ren) is eligible for coverage under another employer-sponsored group health plan through his or her own employment or Spouse's employment.

Dependent children include the Participant's:

a. Natural Child(ren).

b. Stepchildren.

c. Legally Adopted Child(ren) by the Plan Participant and/or Lawful Spouse.

d. Child(ren) for whom the Participant and/or Lawful Spouse has Court-Appointed Legal Guardianship of the Person.

For information about extended coverage for Dependent disabled children, please read refer to page 40 of the SPD.