Roofers Local 149 Security Benefit Trust Fund Open Enrollment Form

Participant Information:

Name: _____ Last four digits Social Security No. _____

Address: _____ Birth Date: _____

Complete the following for each Dependent to be enrolled (if enrolling more than two, attach additional sheets):

Dependent

Name: _____ Relationship: _____ Spouse _____ Child

Birth Date: _____ Address: _____

Last four digits Social Security No. _____ Is this Dependent eligible for other health care coverage? _____ Yes _____ No

Dependent

Name: _____ Relationship: _____ Spouse _____ Child

Birth Date: _____ Address: _____

Last four digits Social Security No. _____ Is this Dependent eligible for other health care coverage? _____ Yes _____ No

If Your Dependent Has Other Coverage:

Adult Child: Adult Children are not eligible for coverage in the 149 Plan if they are eligible for coverage under an employer provided health plan offered by their own employer or a spouse's employer. If you are declining coverage because employer coverage is available, please provide the following information and return this form to the Fund Office by May 31, 2012. If you do so and this coverage involuntarily terminates during the plan year, you can enroll your Adult Child in the 149 Plan if you request enrollment within 30 days of such termination. If you do not, you will have to wait until May 2013 for another enrollment opportunity.

Name of Adult Child: _____

Is the Adult Child currently eligible to enroll in employer-sponsored health plan? ____ Yes ____ No

Provide the Name and Address of the Employer providing such coverage:
_____

Other Dependents: For any other Dependent, if you are declining coverage because other coverage under a group health plan or health insurance coverage is available, please provide the following information and return this form to the Fund Office by May 31, 2012. If you do so and this coverage is involuntarily terminated during the plan year, you can enroll your Dependent in the 149 Plan if you request enrollment within 30 days of such termination. If you do not, you will have to wait until May 2013 for another enrollment opportunity.

Name of Dependent: _____ Relationship: _____ Spouse _____ Child

Provide the name and address of the other coverage: _____

By signing below, I certify that: 1) the information provided above is correct; 2) Dependent coverage is contingent upon my maintaining eligibility as defined in the Plan Document; 3) I will be financially responsible for any claims paid for ineligible Dependents if any of the information above is inaccurate or misleading; and 4) I will provide the Fund office with any documentation necessary to verify that my Dependents are eligible for coverage under the terms of the 149 Plan.

Participant's Signature _____ Date_____

Please return this form to Roofers Local 149 Fringe Benefit Fund Office, P.O. Box 396, Troy, MI 48099-0396, (248) 641-4949 or (888) 868-6411. THIS ENROLLMENT FORM MUST BE RECEIVED BY THE FUND OFFICE BY MAY 31, 2012.
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