



## GREATER ST. LOUIS CONSTRUCTION LABORERS' WELFARE PLAN

### Adult Child (Age 19-26) Enrollment Form

<b>Member Information</b>		
Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Home Address:	City:	State:
Zip Code:	Phone Number:	
<b>Spouse Information</b>		
Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Home Address:	City:	State:
Zip Code:	Phone Number:	
Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Employer:	
Address/Phone Number of Employer:		
Are you covered by another health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Plan:	
Address/Phone Number of Plan:		Group Number:
Are your dependents covered by this health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	What is the maximum age for dependent coverage under this health plan?	

**PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM**

## Adult Child Information

Last Name:		First Name:	Middle Initial:	Phone Number:
Social Security Number:		Date of Birth:		
Home Address:		City:	State:	Zip Code:
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Spouse:		
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>If Yes, please complete this information</b>	Are you eligible for health insurance coverage through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Employer Name:	Employer Phone:		
	Employer Address:	City/State/Zip:		
	If you are employed, you MUST provide a letter, paycheck stub or other document from your current employer stating that either (a) health insurance is <b>available</b> to you through your own active employment or (b) health insurance is <b>not available</b> to you through your own active employment. This document must be on your employer's letterhead or show your employer's company logo.			
If you are married, is your spouse currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No				
<b>If Yes, please complete this information</b>	Are you eligible for health insurance coverage through your spouse's employer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
	Employer Name:	Employer Phone:		
	Employer Address:	City/State/Zip:		
	If your spouse is employed, you MUST provide a letter, paycheck stub or other document from your spouse's employer stating that either (a) health insurance is <b>available</b> to you through your spouse's active employment or (b) health insurance is <b>not available</b> to you through your spouse's active employment. This document must be on the letterhead of your spouse's employer or show the company logo of your spouse's employer.			
Are you eligible for coverage under any other employer-sponsored health plan besides a group health plan of either of your parents? <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer to the above questions is yes, identify the other insurance carrier: _____; Policy Number: _____; Name of Policyholder: _____.				

I certify that:

- The listed Adult Child is eligible for coverage under the terms of the Greater St. Louis Construction Laborers' Welfare Plan.
- The information provided above is correct to the best of my knowledge, and I authorize the release of any information requested to the Greater St. Louis Construction Laborers' Welfare Plan.

I understand that the Greater St. Louis Construction Laborers' Welfare Plan will, from time to time, require updated certification, and that I must notify the Fund Office immediately of any change in the status of my Adult Child (i.e., eligibility for health coverage under any other medical insurance or self-insured plan, including that of an employer).

Signature of Member: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Spouse: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that:

- I have reviewed the information contained on this form and that it is true and accurate.
- I will notify the above named Member in the event that I become eligible for coverage under any other employer sponsored health insurance or self-insured plan (other than those policies or plans sponsored by my parents' employer(s)).

I understand that the Greater St. Louis Construction Laborers' Welfare Plan will, from time to time, require updated certification, and that I must notify the Fund Office immediately of any change in my status as an Adult Child (i.e., eligibility for health coverage under any other medical insurance or self-insured plan, including that of an employer).

Signature of Adult Child: \_\_\_\_\_ Date: \_\_\_\_\_