LOCAL 103

LOCAL 103, I.B.E.W.
HEALTH BENEFIT PLAN

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GCC/IBT 75C RICHARD P. GAMBINO, ADMINISTRATOR
MICHAEL P. DONOVAN, CFO

2016 Re-Enrollment Notice and Form
September 29, 2016

IMPORTANT: Please read this notice carefully. If you have any questions about this notice, please call the Trust Fund Office at (617) 288-5999.

As you know, Local 103, I.B.E.W. Health Benefit Plan (the "Plan") needs to maintain up-to-date information about you and any dependents you may have to enable us to properly provide benefits under the Plan. To do that, routinely we ask you to provide us with certain information about you, your spouse and eligible dependents, if any. **It is extremely important that you complete this Re-enrollment form and return it to the Trust Fund Office by October 31, 2016**.

If you do not complete and return this form to the Trust Fund Office, payment of health claims incurred by you and/or your previously enrolled dependents will be suspended until the Trust Fund Office receives the completed form in its entirety.

I. PARTICIPANT INFORMATION

Name: _____ Social Security Number (SSN): _____

Street Address/P.O. Box No.: _____ City/Town: _____

State: _____ Zip Code: _____ DOB: _____/_____/_____ Marital Status: Married ☐ Single ☐ Widowed ☐

Telephone Number: _____ Email Address: _____

Are you retired? Yes ☐ No ☐

II. SPOUSE AND DEPENDENT CHILD(REN) INFORMATION:

Spouse Name: _____ DOB: _____/_____/_____ SSN: _____

Same Address? Yes ☐ No ☐ ***if NO …** Street Address: _____

City/Town: _____ State: _____ Zip Code: _____ **Is your spouse currently covered by the Plan?** Yes ☐ No ☐

Dependent Child Eligibility Rules: To qualify for dependent coverage under the Plan, a child must: (1) Meet the definition of "child" below; and (2) be under age 26.

"Child": The participant's natural or legally adopted child (including a child placed for adoption), a stepchild (the participant's spouse's natural or legally adopted child), or a child for whom the participant is a court-appointed guardian.

Below, list ALL Your Eligible Children (as described above), if any:

Dependent's Full Name	Date of Birth	Social Security Number
1. _____	_____/_____/_____	_____
2. _____	_____/_____/_____	_____
3. _____	_____/_____/_____	_____
4. _____	_____/_____/_____	_____
5. _____	_____/_____/_____	_____
6. _____	_____/_____/_____	_____
7. _____	_____/_____/_____	_____
8. _____	_____/_____/_____	_____

If you listed any dependent(s) in lines 1 - 8 above, below please identify the relationship to the participant:

	Natural Child	Legally Adopted	Step Child	Guardianship	Are they ***currently*** covered by the Plan? Yes	No
Dependent 1	☐	☐	☐	☐	☐	☐
Dependent 2	☐	☐	☐	☐	☐	☐
Dependent 3	☐	☐	☐	☐	☐	☐
Dependent 4	☐	☐	☐	☐	☐	☐
Dependent 5	☐	☐	☐	☐	☐	☐
Dependent 6	☐	☐	☐	☐	☐	☐
Dependent 7	☐	☐	☐	☐	☐	☐
Dependent 8	☐	☐	☐	☐	☐	☐

If you are adding a dependent to the Plan, please provide a copy of the dependent's;
Marriage Certificate (if applicable), Birth Certificate or Record of Birth, and Social Security Card.

III. PARTICIPANT, SPOUSE AND CHILD(REN) HEALTH INSURANCE INFORMATION

1. Are you, the participant, your spouse or any of your dependents ***eligible*** for Medicare? .....Yes ☐ No ☐

   If YES, please indicate whom and their effective date of eligibility.

   Name: _____ Effective Date: _____/_____/_____

   Name: _____ Effective Date: _____/_____/_____

2. Are you, the participant, your spouse or any of your dependents ***covered*** under Medicare? ..... Yes ☐ No ☐

   If YES, please provide a copy of Medicare card(s) if not already provided. Next, please indicate whom and the effective date of eligibility:

   Name: _____ Effective Date: _____/_____/_____

   Name: _____ Effective Date: _____/_____/_____

3. Have you, the participant, your spouse or any of your dependents received a Social Security Disability Award? ..... Yes ☐ No ☐

   If YES, please provide a copy of the Soc. Sec. Disability Award(s) if not already provided. Next, please indicate whom and the effective date:

   Name: _____ Effective Date: _____/_____/_____

   Name: _____ Effective Date: _____/_____/_____

4. Do you, the participant, your spouse, and/or any of your dependents carry any alternate insurance? ..... Yes ☐ No ☐

   If yes, please identify the insurance plan below:

	Health	Dental	Vision	Prescription
Alternate Insurance Plan 1:	☐	☐	☐	☐

Subscriber's Full Name: _____ Effective Date of Coverage: _____/_____/_____

Name of Other Plan or Insurance: _____ Coverage: Individual ☐ Family ☐

If family coverage, name all covered persons: _____

	Health	Dental	Vision	Prescription
Alternate Insurance Plan 2:	☐	☐	☐	☐

Subscriber's Full Name: _____ Effective Date of Coverage: _____/_____/_____

Name of Other Plan or Insurance: _____ Coverage: Individual ☐ Family ☐

If family coverage, name all covered persons: _____

	Health	Dental	Vision	Prescription
Alternate Insurance Plan 3:	☐	☐	☐	☐

Subscriber's Full Name: _____ Effective Date of Coverage: _____/_____/_____

Name of Other Plan or Insurance: _____ Coverage: Individual ☐ Family ☐

If family coverage, name all covered persons: _____

	Health	Dental	Vision	Prescription
Alternate Insurance Plan 4:	☐	☐	☐	☐

Subscriber's Full Name: _____ Effective Date of Coverage: _____/_____/_____

Name of Other Plan or Insurance: _____ Coverage: Individual ☐ Family ☐

If family coverage, name all covered persons: _____

	Health	Dental	Vision	Prescription
Alternate Insurance Plan 5:	☐	☐	☐	☐

Subscriber's Full Name: _____ Effective Date of Coverage: _____/_____/_____

Name of Other Plan or Insurance: _____ Coverage: Individual ☐ Family ☐

If family coverage, name all covered persons: _____

This form <u>MUST</u> be signed before returning to the Trust Fund Office.

AUTHORIZATION & ACKNOWLEDGEMENT OF DUTY TO PROVIDE ACCURATE, COMPLETE INFORMATION AND UPDATE AS NECESSARY

I understand that the Local 103, I.B.E.W. Health Benefit Plan coverage I am enrolling myself and my dependents (if any) in will remain in effect provided my dependents and I remain eligible under the Plan's terms. I further understand that I am required to notify the Plan promptly of any changes in my status or the status of any of my dependents that would affect eligibility for benefits, including, but not limited to, any change in my marital status, any change in coverage for me, becoming eligible for or covered by Medicare, or any change in my or my dependent(s) eligibility for coverage under this Plan or any other medical plan or health insurance.

I understand that if I knowingly enroll (or continue the enrollment of) any ineligible dependent(s), or if I provide any false or misleading information to the Plan on this form or otherwise, I will be committing fraud on the Plan and acknowledge the Plan's right to recover any benefits that were inappropriately paid on behalf of me or any ineligible dependents(s), and that I may be subject to further penalties, including the loss of my own health coverage and the coverage of my dependent(s). I swear or affirm under the penalties of perjury that the information I have provided on this enrollment form is complete and accurate.

Signature: _____ Date: _____/_____/_____