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

256 FREEPORT ST., 2ND FLOOR, BOSTON, MA 02122
TELEPHONE (617) 288-5999
WWW.TRUSTFUNDS103.COM

TOLL FREE: (800) 564-5999
FAX: (617) 288-6696

MICHAEL P. DONOVAN, ADMINISTRATOR

IMPORTANT NOTICE

TO: Local 103, I.B.E.W. Health Benefit Plan Enrollees

DATE: December 4, 2018

SUBJECT: Re-Enrollment Form

The Local 103, I.B.E.W. Health Benefit Plan (the "Plan") sends the enclosed Re-Enrollment Form to ensure we have the most accurate information on file, and to provide you and your family the best service possible. ***All Local 103, I.B.E.W. Health Benefit Plan participants must complete the enclosed Enrollment Form and return it before December 31st, 2018.*** This Form must be returned to continue coverage under the Plan for you and your family members. ***Failure to return the completed form will result in suspension and / or termination of your coverage.***

If you need to obtain another copy of the Re-Enrollment Form, please visit our website at www.trustfunds103.com or call the Trust Funds Office at (617) 288-5999. ***Please remember to complete the enclosed Re-Enrollment Form and return it by December 31st, 2018 to avoid loss of coverage.*** For your convenience a return envelope has been included in this packet.

Please Mail Forms to:

Local 103, I.B.E.W, Health Benefit Plan
Health Re-Enrollment
256 Freeport Street, 2nd Floor
Boston, MA 02122

Before submitting the enclosed form, please make sure:

- ☐ I have completely answered all the questions.
- ☐ I have signed & dated the back side of the YELLOW form.
- ☐ I have included any necessary paperwork (if applicable).

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

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MICHAEL P. DONOVAN, ADMINISTRATOR

2018 Re-Enrollment Notice and Form
November 28, 2018

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

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 ☐ Divorced ☐

Telephone Number: _____ Email Address: _____

Are you retired? Yes ☐ No ☐

II. SPOUSE AND DEPENDENT CHILD(REN) INFORMATION:

Spouse Eligibility Rules: To qualify for dependent coverage under the Plan, you and your spouse must be validly married under state law. Common-law marriage, domestic partnership, and marriage terminated by divorce or annulment will not qualify your spouse for dependent coverage.

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), the participant's 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, even if they are not covered by the Plan:

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	Is your child ***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:
Your Marriage Certificate (for spousal coverage), the dependent's Birth Certificate or Record of Birth, and the dependent's 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:

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

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

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

If family coverage, name all covered persons: _____

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

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

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

If family coverage, name all covered persons: _____

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

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

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

If family coverage, name all covered persons: _____

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

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

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

If family coverage, name all covered persons: _____

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

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 MUST be signed before returning to the Trust Funds 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: _____/_____/_____