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

256 FREEPORT ST., 2ND FLOOR, BOSTON, MA 02122
TELEPHONE (617) 288-5999
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MICHAEL P. DONOVAN, ADMINISTRATOR

2022 Re-Enrollment Notice and Form
June 1, 2022

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 ☐

If you are adding a Spouse to the Plan, please provide a copy of Marriage Certificate, spouses Birth Certificate and Social Security Card.

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 Eligible Children (as described above) and identify the relationship to the participant. If you are adding a dependent child to the Plan, please check "New Add" and provide a copy of the dependent's Birth Certificate or Record of Birth, and the dependent's Social Security Card. You may be required to provide additional documentation, such as adoption or guardianship papers.

Dependent's Full Name / Date of Birth / Social Security Number	Natural Child	Legally Adopted	Step Child	Guardian-ship
1. _____	☐	☐	☐	☐
Currently Covered by the Plan? Yes ☐ No ☐ New Add to the Plan? Yes ☐ No ☐				
2. _____	☐	☐	☐	☐
Currently Covered by the Plan? Yes ☐ No ☐ New Add to the Plan? Yes ☐ No ☐				
3. _____	☐	☐	☐	☐
Currently Covered by the Plan? Yes ☐ No ☐ New Add to the Plan? Yes ☐ No ☐				
4. _____	☐	☐	☐	☐
Currently Covered by the Plan? Yes ☐ No ☐ New Add to the Plan? Yes ☐ No ☐				
5. _____	☐	☐	☐	☐
Currently Covered by the Plan? Yes ☐ No ☐ New Add to the Plan? Yes ☐ No ☐				
6. _____	☐	☐	☐	☐
Currently Covered by the Plan? Yes ☐ No ☐ New Add to the Plan? Yes ☐ No ☐				
7. _____	☐	☐	☐	☐
Currently Covered by the Plan? Yes ☐ No ☐ New Add to the Plan? Yes ☐ No ☐				
8. _____	☐	☐	☐	☐
Currently Covered by the Plan? Yes ☐ No ☐ New Add to the Plan? Yes ☐ No ☐				

(CONTINUE ON BACK)

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 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 effective date:

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 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 complete below:

		Health	Dental	Vision	Prescription
Covered Individual: _____	Effective Date of Coverage: ____/____/____	☐	☐	☐	☐
Covered Individual: _____	Effective Date of Coverage: ____/____/____	☐	☐	☐	☐
Covered Individual: _____	Effective Date of Coverage: ____/____/____	☐	☐	☐	☐
Covered Individual: _____	Effective Date of Coverage: ____/____/____	☐	☐	☐	☐

This form MUST 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: _____/_____/_____