

2011 Affordable Care Act

** Special Dependent Enrollment Form **

NECA-IBEW Welfare Trust Fund

2120 Hubbard Avenue, Decatur, IL 62526-2871 • Phone: (800) 765-4239

Please complete, sign, and return this form to the Fund Office for each of the following:

This special enrollment opportunity applies to:

- Children whose coverage under the Plan has already ended due to their age; and
- Children who were not previously eligible to enroll in the Plan because eligibility for dependent coverage under the prior Plan provisions ended before the children reached age 26.

Print all information.

Fund Participant's Information

Participant's Full Name: _____
Participant's Social Security Number: _____ Participant's Local Union Number: _____
Participant's Address (Street, Apt. #): _____
City: _____ State: _____ Zip Code: _____
Participant's Home Phone #: _____ Participant's Date of Birth: _____

Dependent Information

Use this section to list eligible dependents who you are adding for coverage. (Attach an additional page if necessary and provide all information).

Dependent Child

Dependent's Full Name: _____
Dependent's Social Security Number: _____
Dependent's Home Phone #: _____ Dependent's Date of Birth: _____
Dependent's Gender: Male Female

Dependent Child

Dependent's Full Name: _____
Dependent's Social Security Number: _____
Dependent's Home Phone #: _____ Dependent's Date of Birth: _____
Dependent's Gender: Male Female

Dependent Child

Dependent's Full Name: _____
Dependent's Social Security Number: _____
Dependent's Home Phone #: _____ Dependent's Date of Birth: _____
Dependent's Gender: Male Female

Employee Authorization

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct and complete. I agree to promptly notify the Fund Trustees in writing in the event of: 1) a change in marital status due to marriage, divorce, or legal separation; 2) the death or disability of a person named here; 3) the birth or adoption of a dependent child; 4) a child's dependent status change due to age. I will reimburse the Fund for any overpayment made to me or in my behalf due to error on this form.

Participant's Name (print): _____
Participant's Signature: _____ Date: _____