PLUMBERS & PIPEFITTERS LOCAL 101
HEALTH AND WELFARE FUND

Adult Child (Age 19-26) Enrollment Form

Member Information

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Home Address:	City:	State:
Zip Code:	Phone Number:	

Spouse Information

Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Home Address:	City:	State:
Zip Code:	Phone Number	
Are you employed? ☐ Yes ☐ No	Name of Employer:	
Address/Phone Number of Employer:		
Are you covered by another health plan? ☐ Yes ☐ No	Name of Plan:	
Address/Phone Number of Plan:		Group Number:
Are your dependents covered by this health plan? ☐ Yes ☐ No	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? ☐ Yes ☐ No	Name of Spouse:		

Are you currently employed? ☐ Yes ☐ No

If Yes, please complete this information:

Are you eligible for health insurance coverage through your employer? ☐ Yes ☐ 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 **available** to you through your own active employment or (b) health insurance is **not available** 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? ☐ Yes ☐ No

If Yes, please complete this information:

Are you eligible for health insurance coverage through your spouse's employer? ☐ Yes ☐ 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 **available** to you through your spouse's active employment or (b) health insurance is **not available** 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?
☐ Yes ☐ 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 Plumbers & Pipefitters Local 101 Health and Welfare Fund.
- The information provided above is correct to the best of my knowledge, and I authorize the release of any information requested to the Plumbers & Pipefitters Local 101 Health and Welfare Fund.

I understand that the Plumbers & Pipefitters Local 101 Health and Welfare Fund 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 Plumbers & Pipefitters Local 101 Health and Welfare Fund 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: ______________