PLUMBERS & PIPEFITTERS LOCAL 553 HEALTH & WELFARE FUND

Adult Child (Age 19-26) Enrollment Form

Member Information

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

Spouse Information

Last Name:	First Name:	Middle Initial:	Date of Birth:
Employer:	Are you covered by Another Plan? ☐ Yes ☐ No Are Dependents Covered on this Plan? ☐ Yes ☐ No		
Name of Plan:	Maximum age for dependent coverage?		

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:	Do you have other coverage available through your spouse's employer? ☐ Yes ☐ No	
Are you currently employed? ☐ Yes ☐ No	Have you elected health insurance coverage through your employer? ☐ Yes ☐ No		
Employer Name:	Employer Phone:		
Employer Address:	City/State/Zip:		

If you elected coverage through any other employer-sponsored health plan besides a group health plan of either of your parents complete below and attach a copy of your insurance card.

Effective Date: _____ 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 553 Health & 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 553 Health & Welfare Fund.

I understand that the Plumbers & Pipefitters Local 553 Health & 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 553 Health & 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 Adult Child: _____ Date: _____