HAGERSTOWN TEAMSTERS AND MOTOR CARRIERS HEALTH AND WELFARE FUND

DEPENDENT ENROLLENT FORM

Note: Please complete this Enrollment Form only if you have a dependent child who is not currently covered by the Fund but who has become eligible for coverage under the new rules defining dependent children.

BASIC INFORMATION

Member's Name: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

_____ Phone #: _____

DEPENDENT ELIGIBILITY

NOTE: CHILDREN are defined as biological, adopted, and step-children, pursuant to custody order or legal guardianship under age 26; lawfully placed foster children; children age 26 and older with permanent disabilities as provided for in the Summary Plan Description.

For each child you are seeking to have covered as a Dependent, provide the following information:

Child 1: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

_____ Phone #: _____

Nature of Relationship: _____

Child 2: _____ Social Security No.: _____

Address: _____ Date of Birth: _____

_____ Phone #: _____

Nature of Relationship: _____

(Add additional pages if necessary)

YOU MUST ATTACH A COPY OF EACH CHILD'S BIRTH CERTIFICATE OR PROOF OF LEGAL GUARDIANSHIP.

(over)

The following applies in the case of a dependent child over the age of 18 who is either currently covered by the Fund or for whom you are seeking coverage under the Fund:

► A dependent child is ***not eligible for coverage under the Fund if s/he is currently eligible for his/her own employer-sponsored health care plan, or is eligible through his/her spouse's employer-sponsored health care plan***. Please check the appropriate box below to indicate whether your dependent child is eligible for his/her own employer-sponsored health care plan, or is eligible through their spouse's employer-sponsored health care plan?

_____ YES (If yes, your dependent child is not eligible to enroll in the Hagerstown Teamsters and Motor Carriers Health & Welfare Fund)

_____ NO

MEMBER CERTIFICATION

I hereby certify that:

_____ (Initial Here) I will notify the Fund's Plan Administrator in a timely manner if or when any of my dependents over the age of 18 becomes eligible to participate in his/her own employer-sponsored health care plan, including his/her spouse's employer-sponsored coverage, and I understand that such notification will thereby forfeit such dependent's right to continue coverage under the Plan as my Dependent.

_____ (Initial Here) The information contained in this Form is true and correct and I understand that the Trustees are relying on this information and the representations I have made in this Form to provide my Dependent(s) with coverage by the Fund.

_____ (Initial Here) If I fail to submit this completed form annually or as otherwise required by the Fund, I understand that my Dependent's eligibility for benefits may be terminated.

_____
Signature of Participant

_____
Date