

**LABORERS' DISTRICT COUNCIL HEALTH & WELFARE TRUST FUND NO. 2**  
**BASIC INFORMATION**

Member's Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

\_\_\_\_\_

Telephone No. \_\_\_\_\_

Active or Retired? \_\_\_\_\_ Date of Retirement: \_\_\_\_\_

Type of Retirement (Normal, Disability, etc.): \_\_\_\_\_

Medicare Eligible? \_\_\_\_\_

**DEPENDENT ELIGIBILITY**

**Are you seeking coverage under the Laborers' District Council Health & Welfare Trust Fund No. 2 for any  
Dependent? \_\_\_ Yes \_\_\_ No**

IF YES, YOU MUST COMPLETE ALL APPLICABLE SECTIONS OF THIS FORM:

**SPOUSE**

Name: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Date of Marriage: \_\_\_\_\_

Date of Spouse's Birth: \_\_\_\_\_

**CHILD(REN) (biological, adopted, and step-children, and grandchildren pursuant to custody order or legal guardianship under age 26; children age 26 and older with permanent disabilities as provided for in Plan)**

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: \_\_\_\_\_

Child 2: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

(Add additional pages if necessary)

**YOU MUST ATTACH A COPY OF YOUR PROOF OF MARRIAGE, ALONG WITH EACH  
CHILD'S BIRTH CERTIFICATE OR PROOF OF LEGAL GUARDIANSHIP.**

The following applies in the case of a dependent child over the age of 18 who is 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. Is your dependent child 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 Laborers' District Council Health & Welfare Trust Fund No. 2

\_\_\_\_\_ 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 under the Plan.

\_\_\_\_\_ (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 Member

Date: \_\_\_\_\_