PRESSMEN WELFARE FUND

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 Pressmen Welfare Plan 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 Pressmen Welfare Plan)

_____ 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: _____

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