Kentucky Laborers District Council Health & Welfare Fund
ADULT DEPENDENT ENROLLMENT FORM

Participant Information:

NAME: ______________________ **SS #:** ______________________
STREET ADDRESS: ______________________ **HOME PHONE #:** ______________________
CITY, STATE, ZIP: ______________________ **DATE OF BIRTH:** ______________________

Children whose coverage ended, or who were denied coverage (or were not eligible for coverage) because the availability of dependent coverage of children ended before attainment of age 26 are now eligible to enroll in the Health & Welfare Fund. Participants may request enrollment for such children within 30 days from the date of termination from previous coverage by completing the bottom of this form. Enrollment will be effective on the date of termination of previous coverage. For more information, contact the Fund Office at (502) 839-8166.

The participant **must certify** that the adult child being enrolled meets **ALL** of the following criteria (please check the boxes to certify agreement):

☐ **The Adult Child was previously removed from coverage, or not eligible for coverage, due to age restrictions; AND**
☐ **The Adult Child is currently under 26 years of age.**

THE HEALTH & WELFARE FUND'S COVERAGE OF ADULT CHILD WILL AUTOMATICALLY END ON LAST DAY OF MONTH IN WHICH ADULT CHILD TURNS 26 YEARS OLD.

Complete this section to enroll Adult Child for coverage.

	Circle Relationship	Adult Child's Name	Birth Date	Social Security #	Is this Adult Child covered by another group medical insurance plan?
ADD	Son / Daughter				____YES ____NO (If yes, please complete plan data below)

Name of other plan and Policy #: Name of Plan:______________________ Policy #:______________________
Name and Birthdate of the Policy Holder: Name:______________________ Birthdate:___ ______________________

	Circle Relationship	Adult Child's Name	Birth Date	Social Security #	Is this Adult Child covered by another group medical insurance plan?
ADD	Son / Daughter				____YES ____NO (If yes, please complete plan data below)

Name of other plan and Policy #: Name of Plan:______________________ Policy #:______________________
Name and Birthdate of the Policy Holder: Name:______________________ Birthdate:___ ______________________

	Circle Relationship	Adult Child's Name	Birth Date	Social Security #	Is this Adult Child covered by another group medical insurance plan?
ADD	Son / Daughter				____YES ____NO (If yes, please complete plan data below)

Name of other plan and Policy #: Name of Plan:______________________ Policy #:______________________
Name and Birthdate of the Policy Holder: Name:______________________ Birthdate:___ ______________________

I have read the information describing the special enrollment opportunity and understand the participation conditions and requirements. By signing below, I certify that: **1)** the information provided above is correct; **2)** All adult child coverage is contingent upon me maintaining my eligibility as defined by the Plan Document; **3)** The dependent(s) listed above has been ineligible for coverage through his/her employer-sponsored health plan and/or his/her spouse's employer sponsored health plan for LESS THAN 30 DAYS from the date this election for dependent coverage with the Fund has been signed and submitted to the Fund by me; and **4)** I will be financially responsible for any claims paid for ineligible adult children if the claims were paid based upon inaccurate or misleading information I have provided above.

Participant's Signature ______________________________ Date________________

Please return this form to: **Kentucky Laborers District Council Health & Welfare Fund**
1996 Bypass South
Lawrenceburg, KY 40342