Benefit Enrollment Form (W) (WASB)

Welfare Fund January 2025

PLUMBERS LOCAL UNION No.1
WELFARE FUND

50-02 5th Street, Long Island City, New York, 11101
Tel. (718) 835-2700

(A) Member Information

Use a ballpoint pen to complete form

[redacted] - [redacted] - [ ][ ][ ][ ]
(1)Social Security Number

(2) Last | (3) First | (4)Intl

(5) Street | (6) City | (7) State | (8) Zip

[ ] (9) Retired [ ] (10) Active

[ ][ ][ ][ ][ ][ ][ ][ ] (11) Date of Birth

[ ] M [ ] F (12) Sex

[ ][ ][ ][ ][ ][ ][ ][ ][ ] (11) Home Phone Number/Cell Number

(12) E-mail Address

[ ][ ][ ][ ][ ][ ][ ][ ][ ] (13) Mobile Phone Number

[ ][ ][ ][ ][ ][ ][ ][ ] (14) Last Date of Employment

(16) Current or Last Employer

(17) Emergency Contact

[ ][ ][ ][ ][ ][ ][ ][ ][ ] (18) Emergency Contact Phone Number/Cell Number

(B) Member Selection

THIS ENROLLMENT FORM IS BEING SUBMITTED FOR: (Please Check All Applicable Boxes)

Type of Coverage Requested ☐ Single ☐ Family

☐ New Enrollment ☐ Address Change ☐ Under Age 65 Retired
☐ Reinstatement ☐ Name Change ☐ Over Age 65 Retired
☐ Termination ☐ COBRA Individual ☐ Surviving Spouse
☐ Other ☐ COBRA Family ☐ Non Medicare Spouse

ELECTION

FROM:	TO:
☐ Empire	☐ Empire
☐ MAPD	☐ MAPD

CHANGE OF DEPENDENTS

☐ Add Spouse ☐ Add Child(ren)
☐ Delete Spouse ☐ Delete Child(ren)

Date of Event [ ][ ] MONTH [ ][ ] DATE [ ][ ][ ][ ] YEAR

(C) Dependent Information:

See the Welfare Summary Plan Description for a definition of Eligible Dependent.

Each Eligible Dependent must be listed on this Enrollment Form signed by you and filed with the Fund Office. If you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll such Dependent. However, you must file with the Fund Office an enrollment form within 180-days after the marriage, birth, adoption or placement for adoption. Eligibility for enrollment received following this 180-day period may be accepted by the Fund. However, eligibility will be effective from the first day of the month in which enrollment was accepted by the Fund. Each change in Dependent Enrollment *(adding or terminating a Dependent)* after the initial enrollment must be submitted with evidence or proof of Dependent status satisfactory to the Trustees.

Name of Spouse	Date of Birth	Date of Marriage	Social Security Number
(1) First / Init. / Last	Month Day Year	Month Day Year	

Name of Dependent	Date of Birth	Relationship to Member	Social Security Number
(2) First / Init. / Last	Month Day Year		
(3) First / Init. / Last	Month Day Year		
(4) First / Init. / Last	Month Day Year		
(5) First / Init. / Last	Month Day Year		
(6) First / Init. / Last	Month Day Year		

(7) Does spouse have own health coverage? ☐ YES ☐ NO If "**Yes**" complete the following information:

NAME OF INSURANCE CARRIER	NAME OF EMPLOYER	POLICY NUMBER	EFFECTIVE DATE

(D) Authorization:

You must sign and date the form in order for your Enrollment to be accepted by the Fund office. amend or revoke your designation at any time

Member Signature: _____ **Date:** _____

I acknowledge that the Plan requires me to reimburse the Plan if I or my dependent recover any amounts from a third party for an illness or injury for which the Plan has paid benefits, or if benefits are paid to me in error. Email and texting are popular and convenient ways to communicate and do hereby give permission to the Fund Office send me general information and reminders via unencrypted email and or text messages to the e-mail address and mobile number I listed above.

(E) TO BE COMPLETED BY FUND OFFICE

GROUP AUTHORIZATION

AUTHORIZED SIGNATURE _____ DATE _____

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] ENROLL TO GROUP NUMBER

Effective Date [ ][ ] - [ ][ ] - [ ][ ][ ][ ]

Termination Date [ ][ ] - [ ][ ] - [ ][ ][ ][ ]

[ ][ ] - [ ][ ][ ][ ][ ][ ] - [ ][ ][ ][ ] REMOVE FROM GROUP NUMBER

NOTE: PLEASE MAKE A COPY OF THE FORM FOR YOUR PERSONAL RECORDS.

ELIGIBILITY FOR DEPENDENTS

Upon becoming eligible for benefits, certain of your Dependents may also become eligible for benefits from this Plan. "Eligible Dependents" are:

- □ Your "Spouse" to whom you are legally married. The Plan does not cover a former spouse. See below for notification requirements upon change of marital status.

- □ Your "Dependent Children" from enrollment until the end of the calendar month in which such children attain age 26. Your children will qualify as Eligible Dependents even if they are eligible for other employment-based coverage other than the plan of a parent or step-parent.

- □ "Dependent Children" are your biological, legally adopted children (including children placed with you for adoption); legally placed foster children or children of your current Spouse. Your Grandchildren are not covered by the Plan unless that child is placed for adoption with you or has been adopted by you.

- □ Your "Disabled Dependent Child" is your Dependent Child over age 26 who is incapable of self-support due to a physical or mental disability. The child must remain continuously disabled, unmarried and incapable of self-support and must either (a) be permanently and totally disabled, live with you for more than one-half of the year and not provide more than one-half of his or her own support or (b) depend on you for more than one-half of his or her financial support. A Disabled Dependent Child remains eligible only so long as you are eligible. You must provide the Fund Office with medical evidence of the child's disability within 45 days of the child's 26th birthday and annually thereafter. However, under certain conditions, you will be permitted to provide the Fund Office with medical evidence every five years thereafter. Please call the Fund Office for more information about this provision.

- □ The Newborn Child of your unmarried dependent, who lives with you for more than one-half of the calendar year or depends on you for more than one-half of his or her financial support, limited to 30 days from date of birth, unless the Newborn Child is adopted by you or is in the process of being adopted by you.

Each Eligible Dependent must be listed on an Enrollment Form signed by you and filed with the Fund Office. If you have a dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll such Dependent. However, you must file with the Fund Office an enrollment form within 180 days after the marriage, birth, adoption or placement for adoption. Eligibility for enrollment received following this 180-day period may be accepted by the Fund. However, eligibility will be effective from the first day of the month in which enrollment was accepted by the Fund. Each change in Dependent Enrollment (adding or terminating a Dependent) after the initial enrollment must be submitted with evidence or proof of Dependent status satisfactory to the Trustees.

Effect of Change in Marital Status on Eligibility

If your marital status changes due to a divorce or legal separation, you are responsible for notifying the Fund Office immediately. Any benefits paid by the Plan on behalf of a divorced Spouse or stepchild after the date of divorce are the financial responsibility of the Employee or the former spouse.

You and your former spouse will be jointly and severally liable for any amounts paid on behalf of your former Spouse or stepchild following a divorce. In addition to having to repay the Plan the costs of any benefits provided on behalf of such former Spouse or stepchild, the Trustees have sole discretion to terminate your eligibility and the eligibility of your Eligible Dependents if you fail to notify the Fund Office of your divorce.

Dependent Eligibility Following the Death of An Active Eligible Employee

Dependents who are eligible for benefits at the time of the death of the Active Eligible Employee continue to be covered by the Plan at no cost for six (6) months following the date of death of the Employee. Thereafter, Dependents may elect to purchase COBRA Continuation as described in the SPD.