

SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN

720 MARKET ST., STE. 700

SAN FRANCISCO, CA 94102

Ph. (415) 263-3670 Fx. (415) 263-3672

An Adult Child age 19 through 25 may be eligible for coverage on the same basis as dependent children under the Plan provided the Adult Child is not eligible to enroll in group medical insurance other than through a plan that covers the other parent. [Note: this “other coverage” rule will no longer apply when/if the Plan loses grandfather status.]

SECTION 4: ADULT CHILD (Age 19 through Age 25) ENROLLMENT INFORMATION					
Adult Child		Birth Date		Soc. Sec. No.	
Adult Child Address					
Is this adult child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Provide Name and Address of Employer:				
Does this adult child have medical insurance available (even if not elected) through his/her employment? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes: Name/Address of Insurance				
	Phone No.		Policy No.		Effective Date
Is other Medical Insurance available through a Parent other than the above named Participant? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes: Parent's Name				Soc. Sec. No.
	Name/Address of Insurance				
	Phone No.		Policy No.		Effective Date
Is other Medical Insurance available (even if not elected) through the spouse of the Adult Child? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Married	If Yes: Spouse's Name				Soc. Sec. No.
	Name/Address of Insurance				
	Phone No.		Policy No.		Effective Date

(A Separate Form Must Be Completed For Each Adult Child Enrollment Request)

PARTICIPANT CERTIFICATION REQUIRED TO REQUEST COVERAGE		
I certify the accuracy of the above information and choose to elect coverage on the indicated Adult Child. I understand that I must inform the Plan Office of any changes in Adult Dependent Status. In understand that I will be responsible for any overpayments that occur if a status change occurs and the Plan Office is not notified.		
Participant Name (Print):	Date:	Phone:
Participant Signature:		Participant SSN: