IBEW LOCAL UNION NO. 654 HEALTH AND WELFARE

c/o Frank M. Vaccaro & Associates, Inc.
27 Roland Avenue, Suite 200, Mt. Laurel, NJ 08054-1056
(856) 793-2501 (800) 883-3682 Fax (856) 793-3105

ENROLLMENT ATTESTATION
ADULT CHILD (Up to Age 26)

Participant Information

Participant Last Name	First Name/Middle Initial	Sex	Date of Birth	Social Security Number
		☐M ☐F	/ /	
Participant Address	City / State Zip			Phone Number

Adult Child Information

Last Name First Name Middle Initial	Sex	Date of Birth	Social Security Number
Address if different than Participant:	☐M ☐F	/ /	

Is the adult child listed above a student:
☐ No.
☐ Yes, Enter name and address of school.

Is the adult child listed above employed:
☐ No.
☐ Yes, Enter name and address of employer.

Does the person listed above have coverage available through any plan other than the IBEW Local Union No. 654 Health & Welfare Fund (other employment, a spouse's employer, a parent, Medicare, etc)? Check the type of benefit that the other plan will cover and the name of the other insurance company or union.

Hospitalization: Medical/Surgery	Major Medical	Drug Card or Prescription Benefit	Dental	Vision
☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐ No

Name and Address of Other Insurance Company — Is this an HMO? ☐Yes ☐ No

Signature and Authorization to Release Information

The Benefits available are subject to the accuracy of the information provided. I agree to be responsible to reimburse the Fund for payment made by the Fund when there are other benefits available. I also agree to the release of information from any employer, insurance company, heath care provider or organization regarding coverage.

Participant Signature _____ Date _____

Adult Child Signature _____ Date _____

General Provisions

If adding an adult child:

1. attach a copy of their birth certificate showing the full name of both parents;
2. if you, as the plan participant, have a stepchild(ren) with a different last name than yours, please provide us with a copy of your marriage license which details the name of the child's biological parent;
3. if you **have** legal custody of a child(ren), adopted a child(ren), please include a copy of the court documentation.

Adult Child Affidavit

By signing this document, I represent that I am not currently eligible to enroll in an employer-sponsored health plan other than my parents' group health plan(s). I will inform the Administrator immediately should I become eligible for such an employer-sponsored health plan in the future.

_____ _____

Adult Child – Print Your Name Adult Child Signature

Date Signed_____

NOTE: If you have more than one eligible adult child, please make copies of this form or call the Administrator at 1-800-883-3682 for an additional Enrollment Attestation form.