UNITED FOOD AND COMMERCIAL WORKERS UNION
LOCAL 152 HEALTH AND WELFARE FUND
27 Roland Avenue, Suite 100, Mount Laurel, NJ 08054
(856) 793-1598 (800) 555-4959 Fax (856) 793-3100

ENROLLMENT FORM FOR ADULT CHILD TO AGE 26 and COORDINATION OF BENEFITS (COB)

Employee (Participant) Information

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

Name of Employer	☐ Full time ☐ Part time	Marital Status: ☐ Single ☐Married ☐Separated ☐ Divorced	Local Union Number	Date of Hire / /

Adult Child Information NOTE: If you have more than one eligible adult child, please make copies of this form or call **Kristen Stamato** at the Fund Office at 1-800-555-4959, extension 2368.

Last Name	First Name	Middle Initial	Sex	Date of Birth	Social Security Number *******REQUIRED*******
			☐ M ☐ F	/ /	

Does the **adult child** listed above have coverage or is coverage available through any Benefit Plan other than this Fund?
__YES __NO **If yes, coverage is through:** __ employment, __a parent, __ **adult child's** spouse, __Medicaid.
Indicate below the type(s) of benefit coverage available and provide the requested insurance company information.

☐ Hospitalization: Medical/Surgery	☐ Major Medical	☐ Drug Card or Prescription Benefit	☐ Dental	☐ Vision

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

Effective Date of Other Insurance	Address of Other Insurance	Phone Number

General Provisions

If adding an Adult child to your Benefit Plan (**INFORMATION REQUIRED for new dependents only**):

1. attach a copy of the birth certificate of the adult child **(must show the full name of both parents),**
2. if you, as the Plan Participant, have a stepchild(ren), please provide a copy of your marriage certificate which details the name of the child's biological parent, in addition to the birth certificate as stated in #1.
3. if you have an adopted child(ren) or a child placed in your home for adoption, please provide a copy of the court documentation, in addition to the birth certificate as stated in #1.

FAILURE TO COMPLY WITH THE REQUIRED INFORMATION UNDER GENERAL PROVISIONS WILL DELAY ENROLLMENT

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.

Employee/Participant Signature: _____	Date _____
Adult Child Signature: _____	Date _____