

## **ADULT DEPENDENT ENROLLMENT APPLICATION (ADE) (AGE 19-26)**

You may apply to enroll or re-enroll any of your adult dependent children who meet the eligibility requirements listed in Section I. Please complete this Section for whom you would like to enroll or re-enroll in the Plan.

Name: _____	Last 4 of Social Security #: _____
Date of Birth: _____	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship: <input type="checkbox"/> Biological Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Adopted Child <input type="checkbox"/> Child Placed with you for Adoption	
➤ Will this dependent be under the age of 26 on <b>April 30, 2017</b> ? <input type="checkbox"/> Yes <input type="checkbox"/> No	
NOTE: Coverage will terminate at the end of the month in which your dependent turns age 26, unless they enroll in and pay for COBRA coverage	
➤ Is the dependent enrolled in coverage under any other plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please indicate:	
Coverage type: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision	
Coverage through: <input type="checkbox"/> Employer <input type="checkbox"/> Member's Spouse <input type="checkbox"/> Adult Dependent's Spouse	
<input type="checkbox"/> Medical Assistance <input type="checkbox"/> Other: _____	
NOTE: If the dependent is also covered under any other plan, a copy of the insurance card is required along with a completed Other-Insurance Questionnaire (form may be obtained from the forms page of our website: <a href="http://IBEW292Benefits.org">IBEW292Benefits.org</a> , or by calling our office)	

Enter the name, ID number, and phone number of the Union Member who could cover the adult dependent under the Plan:

Name of Member: \_\_\_\_\_

Member ID#: **XZ** \_\_\_\_\_

Member's Phone#: \_\_\_\_\_

Adult Dependent's Phone#: \_\_\_\_\_

**Please sign, date, and return this completed form to the 292 Fringe Benefits Office via fax: 763-416-6196, email to [enrollment@IBEW292benefits.org](mailto:enrollment@IBEW292benefits.org) or via mail.**

<p><input checked="" type="checkbox"/> <b>I am applying for enrollment / re-enrollment into the IBEW 292 Health Care Plan for my adult dependent listed above.</b> The information I have provided is accurate and complete to the best of my knowledge. I understand that I must notify the Plan Administrator as soon as possible of the occurrence of an event that affects the eligibility of me or any person covered under the Plan through me to receive benefits under the Plan or the eligibility of such person to have a claim paid under the Plan.</p> <p><b>Member's Signature:</b> _____ <b>Date:</b> _____</p>
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**Completion of this form does not guarantee that the adult dependent listed on this form will be enrolled in the IBEW 292 Health Care Plan. Only those whom the Plan Administrator determines meet the eligibility requirements for enrollment will be enrolled. You will be contacted if additional information is needed.**

# IBEW 292 FRINGE BENEFIT PLANS

6900 WEDGWOOD ROAD N, SUITE 425 - MAPLE GROVE - MINNESOTA 55311  
(763) 493-8830 - (800) 368-9045 - FAX (763) 416-6196 - IBEW292BENEFITS.ORG

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## AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION BY THE HEALTH PLAN

### **\*\* TO BE COMPLETED AND SIGNED BY THE ADULT DEPENDENT \*\***

This form must be completed in its entirety for your Authorization to be Valid.

I authorize the Plan to use of disclose my Protected Health Information ("PHI") as described in this authorization.

- 1) **The Plan can release PHI to:** The Plan, its agents or subcontractors ("Business Associates") is authorized to release the PHI described below to the following person, class of persons, or organization:

- My Parents [Names] \_\_\_\_\_  
 Other [Print Name and Position] \_\_\_\_\_

- 2) **The information that may be used or released is:**

- ANY AND ALL  
 Medical information held by the Plan from the following doctor, clinic, or hospital:  
\_\_\_\_\_  
 Information held by the Plan concerning my eligibility, claims decisions and payments.  
 Other. Please specify: \_\_\_\_\_  
\_\_\_\_\_

- 3) **Right to revoke:** I understand that I have the right to revoke this authorization at any time by notifying the Plan's Contact Person in writing at the above address. I understand that the revocation is only effective after it is received and logged by the Plan. I understand that any use or disclosure made prior to the revocation under this authorization will not be affected by a revocation.
- 4) **Re-Release of Information:** I understand that after this information is released, federal law might not protect it and the recipient might re-release it. I also understand and agree to hold the Plan and any of its agents and subcontractors harmless if the information is re-released.
- 5) **This authorization will expire one year from the date on which you sign it unless you give an earlier date or termination event below.**

- Other: \_\_\_\_\_

Adult Dependent's Signature: \_\_\_\_\_

Date \_\_\_\_\_

Adult Dependent: \_\_\_\_\_

Members Name: \_\_\_\_\_

ID# PIB **XZ** \_\_\_\_\_