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: ☐ Male ☐ Female

Relationship: ☐ Biological Child ☐ Step-Child ☐ Adopted Child ☐ Child Placed with you for Adoption

- Will this dependent be under the age of 26 on **December 31, 2020**? ☐ Yes ☐ 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? ☐ Yes ☐ No

  If yes, please indicate:

  Coverage type: ☐ Medical ☐ Dental ☐ Vision

  Coverage through: ☐ Employer ☐ Member's Spouse ☐ Adult Dependent's Spouse ☐ Medical Assistance ☐ Other: _____

  Coverage effective date: _____

NOTE: *If the dependent is also covered under any other plan, a copy of a completed Other-Insurance Questionnaire is required. (form may be obtained from the forms page of our website: www.IBEW292Benefits.org, or by calling our office 763-493-8830)*

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

Name of Member:_____

Member ID#:_____

Member's Phone#: _____

Adult Dependent's Address:_____

Adult Dependent's Phone#:_____

Please sign, date, and return this completed form to the IBEW 292 Benefits Office via fax: 763-416-6196, email to enrollment@IBEW292benefits.org or via mail.

☒ **I am applying for enrollment / re-enrollment into the IBEW 292 Health Care Plan for my adult dependent listed above.** 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.

Member's Signature: _____ **Date:**_____

Completion of this form does not guarantee that the adult dependent listed on this form will be enrolled in the I.B.E.W. 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.

I.B.E.W. 292 HEALTH CARE PLAN

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

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 DECEMBER 31, 2021 UNLESS YOU GIVE AN EARLIER DATE OR TERMINATION EVENT BELOW.
   - ❑ Other: _____

Adult Dependent's Signature: _____ Date _____

Adult Dependent: _____

Participant's Name: _____ ID# _____