CWA LOCAL 1181 SECURITY BENEFITS FUND

c/o Administrative Services Only, Inc
PO Box 9010 Dept 47
Lynbrook, NY 11563
1-800-537-1238

ENROLLMENT FORM

☐ NEW MEMBER ☐ CHANGE OF ADDRESS ☐ NEW DEPENDENT INFORMATION

ELIGIBILITY STATUS: ☐ ACTIVE-FULLTIME ☐ RETIREE

IF YOU ARE ENROLLING FOR THE FIRST TIME OR CHANGING YOUR MEDICAL PLAN YOU MUST ATTACH A COPY OF YOUR MEDICAL PLAN ID CARD

SECTION I MEMBER INFORMATION

SOCIAL SECURITY NUMBER			DATE OF BIRTH
☐☐☐-☐☐-☐☐☐☐			☐☐/☐☐/☐☐☐☐
LAST NAME	FIRST NAME	MI	
ADDRESS	APT NO.	CITY	STATE ZIP

GENDER: ☐ MALE ☐ FEMALE MARITAL STATUS: ☐SINGLE ☐MARRIED ☐DIVORCED ☐SEPARATED

HOME: CELL: EMAIL ADDRESS

ARE YOU, YOUR SPOUSE OR DEPENDENT CHILDREN COVERED BY ANOTHER

DENTAL PROGRAM? ☐ YES ☐ NO OPTICAL PROGRAM? ☐ YES ☐ NO PRESCRIPTION PROGRAM? ☐ YES ☐ NO

Notice of HIPAA Special Enrollment Rights

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards your or your dependents' other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll your dependents.

To request special enrollment or obtain more information, contact the Welfare Fund Office

SECTION II MEMBER SIGNATURE

I HEREBY CERTIFY THAT ALL THE INFORMATION PROVIDED ABOVE IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT FAILURE TO PROVIDE COMPLETE AND ACCURATE INFORMATION MAY RESULT IN A DENIAL OR SUSPENSION OF BENEFITS. IN ADDITION, ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR THE FUND OR FILES A STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

MEMBER'S SIGNATURE:_____ DATE:____/____/____

SECTION III ☐ SPOUSE - PLEASE ATTACH COPY OF MARRIAGE CERTIFICATE

☐ **DOMESTIC PARTNER** – PLEASE CONTACT ADMINISTRATIVE SERVICES ONLY, INC FOR A DOMESTIC PARTNER ENROLLMENT FORM

SOCIAL SECURITY NUMBER			DATE OF BIRTH
☐☐☐-☐☐-☐☐☐☐			☐☐/☐☐/☐☐
FIRST NAME	LAST NAME	MI	GENDER
			☐ MALE ☐ FEMALE

IS SPOUSE/DOMESTIC PARTNER EMPLOYED? ☐ YES ☐ NO IF YES, EMPLOYER NAME:____________________

DOES THIS EMPLOYER PROVIDE COVERAGE FOR	IF YES, PLEASE PROVIDE NAME OF INSURANCE COMPANY
DENTAL? ☐ YES ☐ NO	
OPTICAL? ☐ YES ☐ NO	
PRESCRIPTION DRUGS? ☐ YES ☐ NO	

SECTION IV DEPENDENT CHILD INFORMATION - COPIES OF BIRTH CERTIFICATES, ADOPTION CERTIFICATES, OR PROOF OF LEGAL GUARDIANSHIP MUST BE ATTACHED.

Children are eligible when they are "Dependent Children" as defined in, i.e., your unmarried children, stepchildren if the signature of your spouse (i.e., the natural parent) is included in the Enrollment Form for the benefit, or legally adopted children; provided such children are dependent upon you for financial support and maintenance and are (1) at least 14 days old but under age 26; or (2) age 26 or older and disabled, provided that they became disabled before attaining age 23 and cannot support themselves because of mental or physical handicap.

As to all other benefits provided for children, your children (including stepchildren, legally adopted children, and foster children placed with you by an authorized placement agency or court order) are eligible when they are less than twenty-six years old.

If your child is mentally ill, developmentally disabled or mentally retarded, or has a physical handicap when coverage would end because of the child's age, coverage (other than life) may be continued if, within thirty-one days after the date benefits would normally cease, you submit proof of your child's incapacity to Administrative Services Only, Inc.

NAME	GENDER	DATE OF BIRTH	SOCIAL SECURITY NO.
	☐M ☐F		☐☐☐-☐☐-☐☐☐☐
IS THE DEPENDENT CHILD LISTED ABOVE ELIGIBLE TO ENROLL IN ANOTHER EMPLOYER SPONSORED HEALTH PLAN ___ Yes ___ No			
	☐M ☐F		☐☐☐-☐☐-☐☐☐☐
IS THE DEPENDENT CHILD LISTED ABOVE ELIGIBLE TO ENROLL IN ANOTHER EMPLOYER SPONSORED HEALTH PLAN ___ Yes ___ No			
	☐M ☐F		☐☐☐-☐☐-☐☐☐☐
IS THE DEPENDENT CHILD LISTED ABOVE ELIGIBLE TO ENROLL IN ANOTHER EMPLOYER SPONSORED HEALTH PLAN ___ Yes ___ No			
	☐M ☐F		☐☐☐-☐☐-☐☐☐☐
IS THE DEPENDENT CHILD LISTED ABOVE ELIGIBLE TO ENROLL IN ANOTHER EMPLOYER SPONSORED HEALTH PLAN ___ Yes ___ No			
	☐M ☐F		☐☐☐-☐☐-☐☐☐☐
IS THE DEPENDENT CHILD LISTED ABOVE ELIGIBLE TO ENROLL IN ANOTHER EMPLOYER SPONSORED HEALTH PLAN ___ Yes ___ No			
	☐M ☐F		☐☐☐-☐☐-☐☐☐☐
IS THE DEPENDENT CHILD LISTED ABOVE ELIGIBLE TO ENROLL IN ANOTHER EMPLOYER SPONSORED HEALTH PLAN ___ Yes ___ No			