BOILERMAKERS
NATIONAL HEALTH & WELFARE FUND

Dependent Child Enrollment Form

Please complete this form and sign at the bottom of the page. Attach an additional sheet if necessary.

Participant Information

_____ _____ _____
Last Name First Name Middle Initial

_____
Social Security Number

Dependent Child Information

List all eligible dependent children not currently covered that you are adding to your coverage. Attach an additional sheet if necessary. ***If the child is a stepchild or if the child's parents are divorced submit a copy of the divorce decree or other court document specifying who has custody and medical responsibility for the child.***

Relationship (ex: Son, Stepdaughter)	**Social Security Number**	**Last Name**	**First Name and Middle Initial**	**Date of Birth** (MM/DD/YYYY)	**Does this child have other group coverage? (Including Medicare)**
					☐ Yes ☐ No
					☐ Yes ☐ No

Declaration of Other Coverage

Complete for each dependent above that has other coverage. This information is required for coordination of benefits purposes. Submit a copy of card(s) for each carrier. Attach an additional sheet if necessary.

Policy Holder: _____ Policy/Group Number: _____

Plan Name & Address: _____

Plan Phone Number: _____

Policy Holder: ☐ Active ☐ Retired Follows Birthday Rule: ☐ Yes ☐ No

Coverage Effective Date: _____ Termination Date: _____

Check Benefits Provided: ☐ Medical ☐ Prescription ☐ Dental ☐ Vision ☐ Mental Health/Substance Abuse

Acknowledgement

The Participant must sign below.

I understand that if I or my dependents provide false information to the Boilermakers National Health & Welfare Fund or conceal information, we could be subject to severe penalties under state and federal law and the Fund may seek to recover benefits wrongfully paid or pursue legal remedies against us. I declare under penalty of perjury that the information provided is true and correct.

_____ _____
Participant's Signature Date