MID-ATLANTIC REGIONAL COUNCIL

CARPENTERS BENEFIT FUNDS

Enrollment Form

Participant Information

Please complete **all** sections.

1. Participant's Information

First Name	M.I.	Last Name	D.O.B.	SSN or UBC #

Street Address	City	State	Zip Code

Home Phone Number	Mobile Number	Email Address

Family Status

☐ Single
☐ Married
☐ Widowed
☐ Divorced
☐ Date of Divorce _____
☐ Children
☐ No Children

2. Participant's Additional Coverage Information (If Applicable)

Do you the Participant have any other coverage besides your MARCC Health Fund Insurance? YES NO

☐ Coverage Through Spouse ☐ Privately Purchased ☐ State Assistance ☐ Medicare ☐ Other:_____

Insurance Company:_____ Policy Number:_____

Policy Holder:_____ Policy Holder D.O.B._____

Effective Date:_____ Type Of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

Participant Statement:

It is my responsibility, to ensure that all accurate information is maintained and kept updated regarding any Health Insurance. If other coverage is added or terminated for any individuals covered under my Group Insurance Program, I will notify the Fund immediately.

I have read this Enrollment and I understand that the MARCC ("Fund") is an Employee Welfare Benefit Plan as defined under Employee Retirement Income Security Act of 1974 ("ERISA"). I understand that any misrepresentation in the information I have provided above will permit the Fund to terminate the coverage of my Spouse, Minor Children, and/or Adult Children and seek any other legal remedies available including possible prosecution for fraud. I authorize the Fund to request and receive any Explanation of Benefits information from Independence Administrators. I authorize the MARCC Health Fund to exchange contact information only (Change of Address, Telephone Numbers, E-mail Addresses, etc.) with your respective Union.

x_____ _____

Signature of Participant **Date**

☐ I would like to receive future correspondence from the Fund via E-mail and Text

Preferred language for communication ☐ English ☐ Spanish

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Spouse Information

Please complete **all Participant Spouse** sections.

Please indicate whether you wish to enroll or opt out your Spouse in the Coverage provided by the Fund

To enroll your Spouse for the first time, please include a copy of their Birth Certificate, Social Security Card and Marriage Certificate.

1. Spouse's Personal Information

Enroll	Opt Out	First Name	M.I.	Last Name	Sex

Social Security Number	Date of Birth	Date of Marriage

Mobile Number	Email Address

2. Spouse's Additional Coverage Information (If Applicable)

Policy Holder's Name:_____ Insurance Company:_____

Policy Number:_____ Effective Date:_____

Please list all who are covered under this plan:_____

_____

Insured By: ☐ Employer Provided ☐ Privately Purchased ☐ State Assistance ☐ Medicare ☐ Retiree

☐ Other:_____

Type Of Coverage: ☐ Single ☐ Family

Benefits Covered: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

By signing below, you attest to the accuracy of the provided information.

x_____ _____

Signature of Spouse **Date**

☐ I would like to receive future correspondence from the Fund via E-mail and Text

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Dependent Information: Child(ren) (Age 0-26)

Please list all Children age 0-26 below, and indicate whether you wish to **Enroll or Opt Out** anyone for Health Insurance provided by the Fund.

In order to enroll a Child or Step Child for the first time, please submit a copy of the Child's Birth Certificate and Social Security Card to the Fund Office.

Enroll	Opt Out	First Name, Middle Initial, Last Name	Relationship to Member	Birth Date	Social Security Number

If any Child(ren) listed above has Health Insurance Coverage other than the Benefits provided by the MARCC Health Fund, please complete the corresponding boxes below. **(Please provide copy of Insurance Cards)**

If any Child (Age 0-26) is on State Sponsored coverage, or their own plan, please indicate "Self" as Policy Holder
If any Child (Age 19-26) is employed and has coverage through their employer please indicate "Self" as Policy Holder

Covered Child_____ Policy Holder D.O.B._____

Policy Holder_____ Policy Holder Relationship to Child_____

Insurance Company _____ Policy Number_____

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date_____

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

If additional boxes are needed please see reverse side.

Covered Child________________________ Policy Holder D.O.B.________________

Policy Holder________________________ Policy Holder Relationship to Child________________

Insurance Company ________________________ Policy Number________________

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date________________

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

Covered Child________________________ Policy Holder D.O.B.________________

Policy Holder________________________ Policy Holder Relationship to Child________________

Insurance Company ________________________ Policy Number________________

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date________________

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

Covered Child________________________ Policy Holder D.O.B.________________

Policy Holder________________________ Policy Holder Relationship to Child________________

Insurance Company ________________________ Policy Number________________

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date________________

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

Covered Child________________________ Policy Holder D.O.B.________________

Policy Holder________________________ Policy Holder Relationship to Child________________

Insurance Company ________________________ Policy Number________________

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date________________

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

Covered Child________________________ Policy Holder D.O.B.________________

Policy Holder________________________ Policy Holder Relationship to Child________________

Insurance Company ________________________ Policy Number________________

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date________________

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

Enrollment form Checklist

Signatures and Enrollment:

- ☐ Are all applicable pages requiring signatures signed and dated?
- ☐ Did you check off the applicable ENROLL / OPT OUT boxes for all Eligible Family Members (spouse and child(ren) 0-26) that you wish to have covered by the Fund for the plan year?

Enrolling a Dependent for the first time? Please send a copy of the following documents:

- ☐ Spouse - Marriage Certificate, Spouse's Birth Certificate and Social Security Card.
- ☐ Child(ren) - Birth Certificate and Social Security Card.
- ☐ Step Child(ren) - Birth Certificate and Social Security Card.

Additional information you may need to send to the Fund:

- If you or your Spouse are currently enrolled in Medicare, please provide the Fund Office a copy of the card if you have not previously done so.
- Please include a copy of all Insurance Cards for any Eligible Family Member(s) other than the Insurance provided by the Fund.
- If your spouse loses employment The Fund would need a termination letter from the employer or the insurance company stating the last date of insurance coverage
- If your documents are in another language please forward translations.

Participant Name: _____ _____ SSN/UBC # :_____