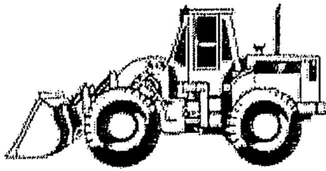

EMPLOYERS AND OPERATING ENGINEERS LOCAL 520

Health & Welfare, Pension, Annuity & Vacation

Eight Executive Woods Court
Swansea, Illinois 62226-2057

618-233-7978
618-233-7979
618-233-7994
Fax: 618-233-7716

STATEMENT OF ADULT CHILD'S ELIGIBILITY FROM AGE 19 UP TO AGE 26 (for use prior to January 1, 2014)

PART I (TO BE COMPLETED BY PARTICIPANT)

______________________	______________________	( ) ______________________	
Participant's Name (Please Print)	Social Security Number	Telephone Number	
Address	City	State	Zip Code
Adult Child's Name (Please Print)	Social Security Number	( ) Telephone Number	
Adult Child's Birthdate (mm/dd/yyyy)	Adult Child's Relationship to Participant		

Is Adult Child employed: ☐ Yes ☐ No ☐ Full-time ☐ Part-time

Name and Address of Employer: ____

Is coverage available to Adult Child under his/her employer's group medical insurance or self-insured plan? ☐ Yes ☐ No

Is coverage available to Adult Child under the group medical insurance or self-insured plan of the employer of Adult Child's spouse? ☐ Yes ☐ No

Is coverage available to Adult Child under any other employer sponsored medical insurance or self-insured plan, other than that of either parent? ☐ Yes ☐ No

Is coverage available to Adult Child under any other group medical insurance or prepayment program? ☐ Yes ☐ No

If the answer to the above question is yes, identify the other insurance carrier:____________________;
Policy Number:______________; Name of Policyholder:______________________________.

I certify that:

- The listed Adult Child is eligible for coverage under the terms of the Welfare Fund; and
- The information provided above is correct to the best of my knowledge, and I authorize the release of any information requested to the Welfare Fund.

I understand that the Employers and Operating Engineers Local No. 520 Health and Welfare Fund will, from time to time, require updated certification, and that I must notify the Fund Office immediately of any change in the status of my Adult Child (i.e. eligibility for health coverage under any other medical insurance or self-insured plan, including that of an employer).

______________________________ ______________

Participant's Signature Date

PART II (TO BE COMPLETED BY ADULT CHILD)

________________________________ ________________________________

Full name of Adult Child Address of Adult Child

I certify:

- I have reviewed the information contained on this form and that it is true and accurate.
- I will notify the above named participant in the event that I become eligible for coverage under any other employer sponsored health insurance or self-insured plan (other than those policies or plans sponsored by my parents' employer(s)).

I understand that the Employers and Operating Engineers Local No. 520 Health and Welfare Fund will, from time to time, require updated certification and that I must notify the Fund Office immediately of any change in my status (i.e., eligibility for health coverage under any other medical insurance or self-funded plan, including that of an employer).

____ __________________

Adult Child's Signature Date