

ADULT DEPENDENT COVERAGE CERTIFICATION FORM

Note: Certification is required annually. All information requested below MUST be completed.

MEMBER INFORMATION (Please print or type):

1. Social Security Number: _____
2. Name (First, Middle, Last): _____
3. Address: Street: _____ City: _____ St: _____ Zip: _____
4. Telephone Number: Home: () _____ Work: () _____

APPLYING FOR ADULT DEPENDENT COVERAGE: (The Adult Dependent must be enrolled in the same plan in which the member is enrolled.)

To apply for Adult Dependent Coverage, this form must be completed and returned to the Fund office.

ADULT DEPENDENT INFORMATION (Please print or type):

5. Dependent's Social Security Number: _____
6. Dependent's Name ((First, Middle, Last): _____
7. Is Dependent's address the same as the member? Yes _____ No _____ (If address is not the same as the member's, please list address below)
8. Address: Street: _____ City: _____ St: _____ Zip: _____
9. Telephone Number: Home: () _____ Work: () _____
10. Dependent's Date of Birth: Month _____ Day _____ Year _____
11. Relationship to member: _____ Natural/Adopted Child _____ Stepchild _____ Other _____
(If other, please explain)
12. Please indicate effective date of coverage: _____

Please answer the following questions:

- Is adult dependent married? Yes _____ No _____
- Does adult dependent have any dependents? Yes _____ No _____
- Is adult dependent enrolled as a full-time student at an accredited educational institution? Yes _____ No _____

(IMPORTANT: IF YES, PLEASE ATTACH PROOF OF FULL-TIME STATUS FROM THE EDUCATIONAL INSTITUTION)

Please indicate the name of the educational institution _____

Is the adult dependent eligible for or provided coverage under any other group or individual health insurance? Yes _____ No _____

Is the adult dependent able to be enrolled in or entitled to benefits under any government health care benefit program (i.e., Medicare, Medicaid)? Yes _____ No _____

AUTHORIZATION FOR APPLICATION FOR ENROLLMENT: I hereby apply for enrollment in health care coverage. I understand this application will be submitted to, and is subject to approval by, the Teamsters Health and Welfare Fund of Philadelphia and Vicinity, providing these and/or other health related benefits and will be subject to the terms of the Fund's Plan. As condition precedent to payment of claims, and in consideration therefore, I also agree that the Fund shall have all legal rights of subrogation on my behalf and/or on behalf of my dependents for recovery against third parties and/or other providers legally obligated to pay such claims. Such subrogation rights shall be satisfied in full prior to the receipt by me or my dependent of any additional recovery or damages from third parties and/or other persons or entities legally obligated to pay such claims. I further agree that I will direct any attorney that I may retain to satisfy such subrogation interest in full and as a priority prior to the distribution of any recovery to me or my dependent. Any additional documents required for release of any such information or records, or for subrogation, will be promptly signed by me and/or my dependent. I further understand that, if at any time I fail to provide accurate information to the Fund, I will be required to repay any payments made as a result of such misinformation and I will be subject to being disqualified from receiving future benefits for such period of time as the Fund deems appropriate. I understand that if I knowingly and with intent to defraud the Fund, file an application for benefits which contains materially false information or conceals information containing a material fact for the purpose of misleading, such actions by me may be deemed to be fraudulent and subject me to criminal prosecution and civil penalties. Finally, I understand that the information contained in this application for enrollment may be used by the Fund for such administrative and actuarial purposes as it deems appropriate.

Member's Signature: _____ Date Signed: _____

Adult Dependent's Signature: _____ Date Signed: _____

Note: Eligibility for benefit coverage as an adult dependent and continuation of this coverage is subject to periodic evaluation and recertification. Should adult dependent or any other information on this certification form change at any time, benefit coverage may be reconsidered by the Fund.