# EMPLOYMENT PARTNERS BENEFITS FUND

## ADULT DEPENDENT ENROLLMENT FORM

### CERTIFICATION OF ELIGIBILITY AND ELECTION TO ENROLL ADULT DEPENDENT

| **Member Name** | | **Member Social** | **Date** | **Phone** |
|---|---|---|---|---|

I certify the accuracy of the following information and elect coverage for the adult dependent indicated below. I understand that I must inform the Welfare Fund of any changes to this information.

**Member Signature:** _____

*Please include the information and make an election below (a natural, step, adopted or foster child age 19 or greater and less than age 26) you wish to have covered under the Welfare Fund's medical benefits.*

### ADULT DEPENDENT INFORMATION

*(also, if relevant- Marriage Certificate, adoption or Foster Documentation)*

| **Name:** | **Social:** | **Relationship:** | **Birthdate (mm/dd/yyyy):** |
|---|---|---|---|
| | | | |

| Do you elect coverage for this adult dependent?<br>☐ **Yes**<br>☐ **No**<br>I understand that if the "YES" box is not checked, no coverage will be provided. | Is this adult dependent employed: ☐ **Yes** ☐ **No** | | |
|---|---|---|---|
| | If Yes: Employer Name: | Employer Phone: | |
| | If Employed, does this dependent have medical coverage through his/her employment?<br>☐ **Yes** ☐ **No** | If yes, Name of other Plan: | Group Policy Number: |
| | Does this dependent have medical coverage through his/her spouse's employment?<br>☐ **Yes** ☐ **No** | If yes, Name of other Plan: | Group Policy Number: |
| | Does your spouse's medical insurance cover this adult dependent? ☐ **Yes** ☐ **No** | If yes, Name of other Plan: | Group Policy Number: |
| | Is this adult dependent in Full-Time Military Service? ☐ **Yes** ☐ **No** | | |

**Please mail to:**
Employment Partners Benefits Fund
50 Abele Rd., Ste. 1005
Bridgeville, PA 15017