Sheet Metal Workers' Health Plan of Southern California, Arizona & Nevada
P.O. Box 10067, Manhattan Beach, CA 90266-8567
Phone (800) 947-4338 Fax (310) 798-0766
Attn: Eligibility Dept.

Participant Data Form

Please Review, Complete (print) and Sign and Date <u>both sides</u> of this Form.
Incomplete forms will be returned to you, and may result in a delay of benefits.

☐ New Member ☐ Add / Delete Dependent ☐ Change Address ☐ Change Beneficiary

Name:	Date of Birth:	Social Security Number:
Street Address:		Local Union #
City, State, Zip		Home Phone #:
Email:	Cell Phone#:	
Employer	Classification	Hire Date
☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced	
Spouse's Employer & City	Spouse's Insurance Co.& City	

List Below all Eligible Dependents (including spouse, if married)
If adding or deleting a dependent, you <u>must</u> submit copies of legal proof of relationship with this form.

Last Name	First Name	MI	Social Security Number	Other Coverage?	Date of Birth	Relationship

Death Benefit Beneficiary (Under the Health Plan)

Last Name	First Name	MI	Social Security Number	Date of Birth	Relationship
Complete Address:					

_____ _____
Signature ***Date***

Please also Read, Sign and Date the Reverse →

* IMPORTANT *

Dependents of participants are eligible for coverage if they meet the rules below and the required documentation of dependent status is submitted to the Administrative Office.

Under the Active Plans, eligible dependents include the participant's:

- ► legal spouse (**former spouses are not eligible after the effective date of the dissolution of marriage or final divorce decree**);
- ► children under 26 years of age;
- ► an unmarried dependent child 26 years of age or older if the child is solely dependent upon the participant for support and is totally prevented from earning a living because of a mental or physical disability. The disabled child must have been disabled while covered under the Plan prior to reaching the limiting age of 26. Alternatively, within the five year period preceding the time the participant began accruing an hour bank leading to the participants' coverage under this Plan, the disabled child must have been disabled while covered under a related multi-employer health plan covering sheet metal workers employed under a collective bargaining agreement with a Sheet Metal Workers International Association local union, prior to reaching the limiting age of 26. The disability must be certified by a Physician and such certification must be submitted to the Administrative Office annually.

Children include the participant's natural child, legally adopted child, child "placed for adoption" if under 18 years old, step-child, or any other child for whom, by a Court Order of Legal Guardianship, or Qualified Medical Child Support Order (QMCSO), the participant is legally responsible for the child's health care expenses. Refer to the "Definitions" section of your Plan booklet for a description of a QMCSO. A child is "placed for adoption" (as stated above) with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.

Newly acquired eligible dependents must be enrolled within 31 days from the date dependency status is met. Otherwise, the dependent's coverage effective date may be delayed until the first of the month following the date the Administrative Office received the required documentation.

You must IMMEDIATELY notify the Administrative Office, in writing, when dependent status changes occur. This includes final dissolution of marriage, death, and any other events which would make your dependent not eligible for further coverage. **If claims and/or premiums are paid for any dependent spouse or child and it is later found that the dependent was not eligible, you and/or the dependent are responsible for reimbursing the Plan for any benefits and/or premiums paid, plus interest, and any costs and attorney's fees if a lawsuit must be filed to recover any benefits overpaid.**

Once enrolled, a dependent who continues to meet the criteria of an eligible dependent, in accordance with the rules of the Plan, cannot be voluntarily dis-enrolled from the Active bargaining Plans A and B.

Dependents who no longer meet the rules of the Plan may be entitled to continue coverage on a self-pay basis, in accordance with the rules and regulations of COBRA. Please refer to the Summary Plan Description for complete details.

Copies of the following documentation MUST be included with this Form in order to add / delete dependents:

Spouse - a copy of your Marriage Certificate **Ex-spouse -** a copy of your divorce decree

Children - a copy of their Birth Certificate and/or Court Orders. For newborns, please submit a copy of the hospital's *Verification* or *Certification of Birth* as soon as possible.

Enclosed are copies of all necessary documents. I hereby certify that the foregoing statements, including any accompanying statements and documents are true, correct, and complete to the best of my knowledge. I understand that incomplete Data Forms will be returned to me, and eligibility for benefits on dependents will not be verified until the proper documents are received in the Administrative Office. I also understand that I must immediately notify the Administrative Office, in writing, when dependent status changes occur.

_____ _____

Signature ***Date***