

RETURN THIS FORM TO FUND OFFICE
IN THE ENCLOSED SELF ADDRESSED ENVELOPE!!

Sheet Metal Workers' Local 73 Welfare Fund

4530 Roosevelt Road, Hillside, Illinois 60162~Phone: 708-449-7373~Fax 708-449-7458~www.sm73funds.org

**SPECIAL ENROLLMENT OPPORTUNITY
FOR DEPENDENT CHILDREN UNDER AGE 26 OR
INDIVIDUALS WHO LOST COVERAGE DUE TO REACHING RETIRED PLAN'S LIFETIME LIMIT**

The Patient Protection and Affordable Care Act extends dependent coverage to children up to age 26 or to individuals who lost Plan coverage due to reaching the Retired Plan's lifetime maximum. If you or your dependents are now eligible for Plan coverage, you have a special enrollment opportunity to enroll yourself or your eligible dependent child in the Plan.

For coverage to be effective July 1, 2011, you must send this completed form and any required documentation to the Fund Office at the address above by June 30, 2011 (dropped off, postmarked or faxed).

Participant Information

Participant Full Name: _____ Participant SSN: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone #: _____ Date of Birth: _____ Marital Status: Single Married Divorced Widowed

Dependent Information

Provide all information for eligible dependents to be covered under the Plan.

Dependent's Full Name (First, MI, Last)	Relationship	Gender		Social Security Number	Date of Birth (mm/dd/yyyy)	Currently Insured?		If Yes, please specify Policyholder: DE = Dependent's Employer, DSE = Dependent's Spouse's Employer or O = Other - please specify
		F	M			Y	N	
		<input type="checkbox"/>	<input type="checkbox"/>		/ /	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>		/ /	<input type="checkbox"/>	<input type="checkbox"/>	
		<input type="checkbox"/>	<input type="checkbox"/>		/ /	<input type="checkbox"/>	<input type="checkbox"/>	

If dependent's address is different from Participant, provide information below:

Address: _____ City: _____ State: _____ Zip Code: _____

Dependent Documentation/Proof

You must also enclose a CERTIFIED STATE OR COUNTY duplicate of the birth certificate to add a child. A certified duplicate is a copy acquired from the state or county in which the birth occurred. Hospital and church records are not acceptable. All information must be completed and provided or your dependents will not be enrolled under your group health care coverage. **If your dependent was previously covered under the Plan, you ARE NOT required to provide your birth certificate.**

Participant Authorization

I understand that the information on this form will be used to determine eligibility for coverage for my dependent(s) under the Sheet Metal Workers' Local 73 Welfare Fund effective July 1, 2011. I hereby certify that the information on this form, to the best of my knowledge and belief, is true, correct, and complete. I also understand that willingly falsifying any of the information on this form is considered to be fraud and may be cause for termination of coverage and may also be subject to penalties.

Participant Name (print): _____

Participant Signature: _____ Date: _____

Dependent's Signature: _____ Date: _____