Local 1298 Welfare Fund

SPECIAL ENROLLMENT FORM FOR CHILDREN UNDER AGE 26

** Please return this form as soon as possible. If the form is not returned by the end of the month in which the dependent child turns 19, coverage will terminate until form is received. Form can be mailed to Local 1298 Benefit Funds 681 Fulton Ave Hempstead NY 11550 or faxed to 516-489-0369. **

Participant Information:

Last Name	First Name	Middle Initial (MI)

Mailing Address	Social Security #

City	State	Zip code

Gender	Date of Birth (Month/Day/Year)	Daytime Phone Number	Cell/Phone Number	Are you currently enrolled in the Plan?
☐ F ☐ M		( )	( )	☐ Yes ☐ No (if no, you must be enrolled in order to cover your dependent children)

Child Enrollment: Complete this section for **each** child you wish to enroll (add) to coverage.

Last Name	First Name	MI	Sex	DOB	SS#	Previously enrolled in Plan
			☐ F ☐ M			☐ Yes ☐ No
			☐ F ☐ M			☐ Yes ☐ No
			☐ F ☐ M			☐ Yes ☐ No

You must provide a copy of the child's birth certificate or proof of adoption.

Other Health Care Coverage Information:
Complete the following section if your dependent child(ren) is ***currently* eligible for or covered *by other employer-based group health coverage*** either through his/her own employment, his/her spouse's employment or through your spouse.

Policyholder's Name:	Relationship to dependent: ☐ Self ☐ Parent ☐ Spouse	DOB:	Group and Policy #:

Insurance Company:	Ins. Company Address:	Phone #:

Employer:

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that any intentional misrepresentation of material facts on this application may cause the retroactive termination or rescission of my coverage.

_____ _____ **Date**_____

Signature of Adult Child Applying for Coverage **Signature of Member**