• NECA/IBEW FAMILY MEDICAL CARE PLAN • 5837 Highway 41 North • Ringgold, GA 30736

FAMILY ENROLLMENT FORM

COMPLETE AND RETURN TO ADDRESS SHOWN ABOVE

Name of Employee _____ Soc. Sec. No. _____

Address _____
(street number and street name)

_____ Telephone No. (_____) _____
(city, state, zip code)

Local Union No. _____ Current Employer _____
(name, city, state, zip code)

Job Class: Journeyman (or above) Apprentice Construction Elec. Construction Wireman Non-Bargained-for Other: _____
(circle one)

Date of Birth _____ Sex: M F Marital Status: Single Married Div Sep Legally Sep. Widowed
(circle one) (circle one)

Name of Spouse _____ Date of Birth _____ Soc. Sec. No _____

NEW EMPLOYEES OR NEW SPOUSES—ATTACH CERTIFIED COPY OF MARRIAGE CERTIFICATE.

Name of any family member through which other group coverage is provided _____

Name, address, telephone no., and group/member I.D.s for that health plan _____

_____

List all dependent children under age 26

Full Legal Name	Relationship to you (natural child, stepchild, etc.)	Does child live with you?	Child's Social Security Number	Date of Birth	Sex
1.					
2.					
3.					
4.					
5.					
6.					

FOR ANY NEWLY ENROLLED CHILD LISTED ABOVE WHO WAS NOT BORN OF YOUR CURRENT MARRIAGE, PLEASE SUBMIT CERTIFIED BIRTH CERTIFICATE AND COPIES OF ALL PERTINENT COURT ORDERS (DIVORCE DECREES, CUSTODY AWARDS, PATERNITY ORDERS, ETC.).

LIFE INSURANCE BENEFICIARY

Designate one or more beneficiaries for your Life Insurance and AD&D Insurance benefits.

Primary Beneficiary(ies):

Full Legal Name	Relationship to You	Social Security Number	Date of Birth	% of total (must equal 100%)

Contingent Beneficiary(ies) - Insurance benefits will only be paid to a contingent beneficiary if there is no surviving primary beneficiary:

Full Legal Name	Relationship to You	Social Security Number	Date of Birth	% of total (must equal 100%)

The above-named beneficiary supersedes any and all beneficiaries previously designated. Designation of a beneficiary on this form will be valid only if the Fund Office receives this form while you (the employee) are still living.

_____ _____

Date Signed Employee Signature

NECA/IBEW FAMILY MEDICAL CARE PLAN
5837 Highway 41 North
Ringgold, GA 30736
Telephone 1-706-937-9600 or 1-877-937-9602 Fax 1-706-937-9601

NOTIFICATION FORM TO ELECT OR REJECT FAMILY COVERAGE

For Employees in Plan S

To New Employees in Plan S:

The NECA/IBEW Family Medical Care Plan has received notification or employer contributions indicating that you are a new participant in Plan S.

Plan S provides single-only coverage with optional family coverage. The cost of family coverage is currently $131 per month. Your dependents will not be eligible for benefits unless you elect family coverage and make monthly self-payments for their coverage. **You must elect or reject family coverage at this time by completing the information below and returning this form to the Fund Office.**

_____ _____ _____
Your first, middle and last name Your SS # Your Date of Birth

_____ (____)_____
Your street address with city, state and Zip Your Phone Number

Initial the applicable paragraph below:

_____ Yes, I want to elect family coverage under the NECA/IBEW Family Medical Care Plan.

_____ No, I do not want family coverage. I understand that if I do not elect family coverage at this time, I cannot add my current dependent(s) until the next semi-annual open enrollment period (for coverage starting January 1 or July 1). "Late enrollment," which is explained on the reverse, is an exception to this rule.

By signing below you certify that you have read and understand the rules governing coverage under the NECA/IBEW Family Medical Care Plan.

⇨ _____ _____
Employee's Signature **Date**

Return this form to the NECA/IBEW Family Medical Care Plan at the address shown at the top of this form. Keep a copy for your records. A Family Enrollment Form must be enclosed with this notification before the employee can be enrolled. If family coverage is desired, a check in the amount of the first month's coverage must also be enclosed. Make check payable to the NECA/IBEW Family Medical Care Plan.

(over)

RULES GOVERNING OPTIONAL FAMILY COVERAGE

1. If you do not elect family coverage at this time, you cannot add your dependent(s) until the next semi-annual open enrollment period (for coverage starting January 1 or July 1). "Late enrollment," which is explained below, is an exception to this rule. (Also see rule No. 7.)

2. Failure to submit a completed and signed notification form is a rejection of family coverage at this time.

3. Your self-payments are due by the first day of the month for which you are purchasing dependent coverage; however, if you make the payment within the 30-day grace period following the first of the month, the payment will be accepted. Make your payments by check or money order to the NECA/IBEW FAMILY MEDICAL CARE PLAN, 5837 Highway 41 North, Ringgold, GA 30736.

   The self-payment amount for family coverage is determined by the Trustees and may be changed at any time.

4. All your family members who meet the Plan's definition of a dependent will be covered by your election and payment for family coverage. You cannot pay to cover other family members who do not qualify for coverage under the terms of the Plan. Your payment will be the same regardless of how many dependents you have. The benefits for which eligible dependents will be eligible are shown on the Plan S Schedule of Benefits.

5. Even if you make the required payments, your dependents will not be eligible for benefits during any period of time during which you (the employee) are not eligible, or the family member does not meet the Plan's definition of a dependent (see your SPD).

6. If you fail to make a correct and timely self-payment, or if you voluntarily stop making self-payments for dependent coverage, your dependents' eligibility will terminate at the end of the last month for which you made a correct payment. Their coverage cannot be reinstated except during the semi-annual open enrollment periods for coverage effective January 1 or July 1. (However, if your job classification changes and you become eligible for another plan provided by the NECA/IBEW Family Medical Care Plan that does not require you to pay for family coverage, your dependents will become eligible under your new plan when you do.)

7. You may add dependent coverage if you acquire a new dependent later (for example, if you get married or have a child). In such case, you must notify the Fund Office within 30 days of acquiring the new dependent. You will also have to complete a dependent coverage election form and submit documentation that the person meets the Plan's definition of a dependent.

8. The following rule may apply if your dependents are covered under another plan at this time.

   Late Enrollment Rule: If, on the date you could be eligible under the Plan, your dependent is covered under another group health plan or private health insurance, either as an employee or a dependent, then you can add that family member to your coverage later. You must make application within 30 days of the date the other coverage ends, and must submit written documentation from the other employer or health plan showing the effective date and termination date of the other coverage. You will ONLY be able to add those family members who were covered under the other plan.

9. You are not required to reject family coverage because a dependent has other coverage. The NECA/IBEW Family Medical Care Plan coordinates its benefits with other group plans. (See the Coordination of Benefits rules in the Summary Plan Description booklet for more information).