REQUEST FOR COVERAGE OF ADULT CHILD(REN) UP TO AGE 26

ACTIVE MEMBERS ONLY

Submit Form to:
SOC Health & Welfare Fund
40 Peck Slip
New York, New York 10038

The Patient Protection and Affordable Care Act (PPACA) allows young adults, up to age 26, to continue his/her coverage through his/her parent's group health benefits through age 26. This option is available for the SOC Fund on January 1, 2011 and provides for continued coverage for the Prescription Drug Plan only.
The young adult coverage is subject to all terms and conditions of the plan. The adult child can only enroll under the plan in which his/her parent is currently enrolled.
Directions: To enroll your Adult Child(ren) (or for enrollment to continue for adult child(ren) who are currently full-time college students) who have not yet reached age 26, please complete this form and return it to the Fund Office to establish eligibility.

ADULT CHILD UP TO AGE 26 INFORMATION

Name and Mailing Address of Young Adult:

Social Security Number:
XXX-XX-

Telephone Number (with area code)

PARENT ENROLLEE INFORMATION

Name and Mailing Address of covered parent:

Social Security Number:
XXX-XX-

Telephone Number (with area code)

Tax ID #

To qualify for coverage of an adult child up to age 26, you must be able to check "True" for all of the following statements:

1. I am the natural or adopted child of a current active Fund member or his/her spouse. ☐ True ☐ False
2. I am **NOT** eligible for other group health plan coverage through either my employer or my spouse's employer sponsored plan. ☐ True ☐ False

EVIDENCE REQUIRED, WHICH MUST BE SUBMITTED AT TIME OF ENROLLMENT

ADULT CHILD UP TO AGE 26

Copy of Birth Certificate ☐ Yes ☐ No

EMPLOYER VERIFICATION - TO BE COMPLETED BY ADULT CHILD'S EMPLOYER AND IF MARRIED, MUST ALSO BE COMPLETED BY THE ADULT CHILD'S SPOUSE'S EMPLOYER

I certify that I am authorized to make the following representations concerning the above named Adult Child and recognize that the SOC Health & Welfare Fund shall be entitled to rely on the truth of my statement below:
He/she is not eligible for other group health plan coverage through his/her employer because his/her employer does not offer group health plan coverage to the above-named Adult C **OR**
He/she is not eligible for other group health plan coverage through his/her spouse's employer because his/her spouse's employer does not offer group health plan coverage to the above-named Adult Child.

Adult Child's Employer		**Adult Child's Spouse's Employer**	
Print Name:		**Print Name:**	
Signature:		**Signature:**	
Title:		**Title:**	
Company Name:		**Company Name:**	
Date:		**Date:**	
Phone:		**Phone:**	

YOUR COVERAGE WILL TERMINATE WHEN:

1. You voluntarily elect to terminate your coverage by sending notice to the Fund Office;
2. Your parent is no longer enrolled in the SOC Health & Welfare Fund; or
3. You no longer meet the eligibility requirements for Coverage of Adult Children Up to Age 26, e.g. , you become eligible for other employer sponsored health benefits coverage or you reach age 26.

PLAN SELECTION

I am making an election for enrollment of my Adult Child up to age 26. To the best of my knowledge and belief, all of the answers provided on this form are true and correct. I have read and understand the rules regarding termination of coverage. Specifically, I understand that if my adult child's employer, or my adult child's spouse's employer, offers group health plan coverage for my adult child, I must notify the Fund Office of this event and understand that coverage of my adult child under the Fund's prescription drug plan must be terminated. I understand that any false or misleading statement made in order to receive benefits for which my Adult Child up to age 26 is not qualified will subject me to financial responsibility for any benefits paid and/or other legal actions appropriate to the prosecution of such fraud.

☐ I wish to enroll my Adult Child Up to Age 26. If you have any questions, please contact the Fund Office at 212 964-7500.

Parent Member Signature: _____

Printed Name: _____

Date: _____

Sworn to Before Me

This _____day of _____, 202_____

_____

Notary Public

Please complete this form and return it to the SOC Health & Welfare Fund, 40 Peck Slip, New York, New York 10038

FOR FUND OFFICE USE ONLY:

This application is: ☐ Approved ☐ Denied

If application is denied, reason for denial: _____

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