



JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY

158-11 HARRY VAN ARSDALE JR. AVENUE • FLUSHING, N.Y. 11365
TEL: (718) 591-2000 • FAX: (718) 380-7741 • www.jibe.org

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Dear Participant:

Various benefits are administered through the Joint Industry Board, which provides coverage for both the participant and the eligible dependents of the participant. You may participate in some or all of these plans.

A. The Pension, Hospitalization and Benefit Plan of the Electrical Industry, The Deferred Salary Plan of the Electrical Industry, The Health Reimbursement Account Plan of the Electrical Industry

Eligible dependents are 1) spouse and 2) children from birth up to their 26th birthday, regardless of marital or student status. However, adult children over age 19 may only be covered under the Pension, Hospitalization and Benefit Plan if other health coverage is not available to them through their own or their spouse's employer. Participants enrolling an adult child must sign an affidavit that verifies that no such coverage is available to the adult child.

B. The Dental Benefit Plan of the Electrical Industry, The Dental Benefit Plan of the Elevator Division

Eligible dependents are 1) spouse and 2) unmarried children from birth up to their 19th birthday. However, full-time unmarried dependent students attending accredited institutions of higher learning shall be covered up to age 25 years. An original letter from the college registrar for the current semester shall be required as proof of current college attendance. The term "children" shall mean natural or legally adopted children.

The proper recording of your eligible dependents, and any other group health coverage available to them, will facilitate payment of future claims. Please complete the enclosed forms and return them in the enclosed envelope, with a copy of the applicable marriage certificate, birth certificate(s) or adoption papers so that your eligible dependents may be properly recorded and enrolled.

In order to avoid a delay in processing, please include Social Security numbers for all dependents.

ME-52

DEPENDENTS BENEFIT FILE

SOC. SEC. #

I.D.

MEMBER'S NAME

 LAST

FIRST

MEMBER'S DATE OF BIRTH

SEX

ELIGIBLE DEPENDENT INFORMATION

	SPOUSE NAME	BIRTHDATE	SEX M or F	SOCIAL SECURITY #
<input type="text" value="02"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	CHILD NAME	M D Y		
<input type="text" value="03"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	CHILD NAME	M D Y		
<input type="text" value="04"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	CHILD NAME	M D Y		
<input type="text" value="05"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	CHILD NAME	M D Y		
<input type="text" value="06"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	CHILD NAME	M D Y		
<input type="text" value="07"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	CHILD NAME	M D Y		
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	CHILD NAME	M D Y		

For Office Use Only

COLLEGE DATE

 M D Y

 M D Y

 M D Y

 M D Y

 M D Y

For Office Use Only

- NEW
- ADD DEPENDENT
- DELETE DEPENDENT
- CHANGE ONLY
- ELI FILE
- DEN FILE

EFFECTIVE DATE

Member's Signature _____ Date _____

PENSION, HOSPITALIZATION AND BENEFIT PLAN OF THE ELECTRICAL INDUSTRY

COORDINATION OF BENEFITS FORM

Participants of the Pension, Hospitalization AND Benefit Plan of the Electrical Industry (“the Plan”) are subject to the Coordination of Benefits (“COB”) provision. Under this provision, you must notify the Plan of any other Group Health Plan coverage you or your eligible dependents may be enrolled in.

Please complete all applicable sections of this form, sign and return it to the Members’ Records Department at the Joint Industry Board, located at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365.

SECTION: PARTICANT INFORMATION:

Last Name First Name

Social Security Number Date of Birth

Address

SECTION 2: COORDINATION OF BENEFIT INFORMATION:

If your dependent is a participant in another group health plan, please provide information about this coverage below:

1. Dependent’s Name: _____

Name of Dependent’s health plan: _____

2. Dependent’s Name _____

Name of Dependent’s health plan: _____

Effective date of coverage: _____

Relation to Participant (check one): spouse child

2. Dependent’s Name: _____

Name of Dependent’s health plan: _____

Effective date of coverage: _____

Relation to Participant (check one): spouse child

SECTION 3: PARTICIPANT’S SIGNATURE

Please print and sign your name and date this form.

Sign Name

Date

Print Name