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.jibei.org

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 – Pension Trust Fund, The Annuity Plan of the Electrical Industry

The Pension, Hospitalization and Benefit Plan of the Electrical Industry – Pension Trust Fund and the Annuity Plan of the Electrical Industry provide valuable benefits for your retirement. Please keep the enclosed Summary Plan Descriptions in a safe place for reference.

B. 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.

C. The Dental Benefit Fund of the Electrical Industry

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 26 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.

D. 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 26 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.

ENROLLMENT FORM
PENSION, HOSPITALIZATION AND BENEFIT PLAN
OF THE ELECTRICAL INDUSTRY

SECTION 1: PARTICIPANT INFORMATION:

Last Name _____ First Name _____

Social Security Number _____ Date of Birth _____

Address _____

Phone Number _____ Cell Phone Number _____ Email Address _____

SECTION 2: DEPENDENT INFORMATION:

1. Relation to Participant (check one): ☐ spouse: date of birth: _____ ☐ child: date of birth _____

Last Name _____ First Name _____ Social Security Number _____

Address _____

2. Relation to Participant (check one): ☐ spouse: date of birth: _____ ☐ child: date of birth _____

Last Name _____ First Name _____ Social Security Number _____

Address _____

3. Relation to Participant (check one): ☐ spouse: date of birth: _____ ☐ child: date of birth _____

Last Name _____ First Name _____ Social Security Number _____

Address _____

The Pension, Hospitalization and Benefit Plan of the Electrical Industry
158-11 Harry Van Arsdale Jr. Avenue
Flushing, NY 11365
Phone: (718) 591-2000 Fax: (718) 380-7741

Please Turn Over

4. Relation to Participant (check one): ☐ spouse: date of birth: _____ ☐ child: date of birth_____

_____

Last Name First Name Social Security Number

_____

Address

5. Relation to Participant (check one): ☐ spouse: date of birth: _____ ☐ child: date of birth_____

_____

Last Name First Name Social Security Number

_____

Address

6. Relation to Participant (check one): ☐ spouse: date of birth: _____ ☐ child: date of birth_____

_____

Last Name First Name Social Security Number

_____

Address

7. Relation to Participant (check one): ☐ spouse: date of birth: _____ ☐ child: date of birth_____

_____

Last Name First Name Social Security Number

_____

Address

SECTION 3: COORDINATION OF BENEFIT INFORMATION

If you or a dependent are a participant in **another group health plan**, please provide information about your coverage below:

Name of other health plan: _____

Type of Plan (check one): ☐ Individual ☐ Family

Name of Person(s) Covered: _____

Policy Holder is (check one): ☐ Actively Working ☐ Retired ☐ Other (i.e. disabled)

Effective date of coverage: _____

SECTION 4: PARTICIPANT'S SIGNATURE

Please print, sign your name, and date this form.

_____ _____

Print Name Date

_____

Sign Name