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.


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

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       DOB: ___________   ☐ child       DOB: ___________   M/F _________

Last Name            First Name            Social Security Number

Address

2. Relation to Participant (check one): ☐ child       DOB: ___________   M/F _________

Last Name            First Name            Social Security Number

Address

3. Relation to Participant (check one): ☐ child       DOB: ___________   M/F _________

Last Name            First Name            Social Security Number

Address

Please Turn Over

H-114 (10/2019)
4. Relation to Participant (check one): □ child  DOB: ____________  M/F ____________

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 complete information about your coverage below and attach a copy of your health insurance card (front and back):

Name of other health plan: ______________________________________________________

Name of Policy Holder: ________________________________________  DOB: ____________

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