



## 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](http://www.jibei.org)

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**LANCE VAN ARSDALE**

Dear Participant:

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

**A. Pension, Hospitalization and Benefit Plan of the Electrical Industry – Pension Trust Fund; 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. Pension, Hospitalization and Benefit Plan of the Electrical Industry; Deferred Salary Plan of the Electrical Industry; Health Reimbursement Account Plan of the Electrical Industry**

Eligible dependents are: 1) spouse and 2) children from birth up to their 26<sup>th</sup> birthday, regardless of marital or student status.

**C. Dental Benefit Fund of the Electrical Industry**

Eligible dependents are: 1) spouse and 2) unmarried children from birth up to their 19<sup>th</sup> 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. Dental Benefit Plan of the Elevator Division**

Eligible dependents are: 1) spouse and 2) unmarried children from birth up to their 19<sup>th</sup> 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.

**To avoid a delay in processing, please include Social Security numbers for all dependents.**

Sincerely,  
Members' Records Department

ME-52  
Enc.

**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**

## **ENROLLMENT FORM**

### **SECTION 1: PARTICIPANT INFORMATION:**

\_\_\_\_\_  
Last Name First Name

Assigned Sex at Birth: M ☐ F ☐

Current Sex: M ☐ F ☐ Other ☐

\_\_\_\_\_  
PID (Magnacare ID #) 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: \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name Social Security Number

Assigned Sex at Birth: M ☐ F ☐

Current Sex: M ☐ F ☐ Other ☐

\_\_\_\_\_  
Address

2. Relation to Participant (Check One): ☐ Child DOB: \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name Social Security Number

Assigned Sex at Birth: M ☐ F ☐

Current Sex: M ☐ F ☐ Other ☐

\_\_\_\_\_  
Address

3. Relation to Participant (Check One): ☐ Child DOB: \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name Social Security Number

Assigned Sex at Birth: M ☐ F ☐

Current Sex: M ☐ F ☐ Other ☐

\_\_\_\_\_  
Address

4. Relation to Participant (Check One): ☐ Child DOB: \_\_\_\_\_

\_\_\_\_\_  
Last Name First Name Social Security Number

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐

\_\_\_\_\_  
Address

### **SECTION 3: COORDINATION OF BENEFIT INFORMATION**

If you or a dependent are a participant in **another group health plan**, please complete the 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)

### **SECTION 4: PARTICIPANT'S SIGNATURE**

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

\_\_\_\_\_  
Print Name Date

\_\_\_\_\_  
Sign Name