



The Joint Industry Board of the Electrical Industry  
158-11 Harry Van Arsdale Jr. Avenue • Flushing, NY 11365-3095  
Tel: (718) 591-2000 | Fax: (718) 380-7741 | [www.jibei.org](http://www.jibei.org)

Dear Participant:

The Joint Industry Board administers several benefits that will cover you and eligible dependents. You may participate in some or all these plans. Please keep the enclosed Summary Plan Descriptions (SPD's) in a safe place for future reference or you can access additional information on [www.jibei.org](http://www.jibei.org) website.

**A. Pension, Hospitalization and Benefit Plan of the Electrical Industry Health and Welfare Plan – 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.

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

**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**

**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 health coverage available to them, will support timely processing of future claims. Please complete the enclosed forms and return them in the enclosed envelope with a copy of the required 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.

## 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

Enrolled in **another health plan?** Yes  No  **If yes, complete section 3.**

### 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

Enrolled in **another health plan?** Yes  No  **If yes, complete section 3.**

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

Enrolled in **another health plan?** Yes  No  **If yes, complete section 3.**

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

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Last Name	First Name	Social Security Number
Assigned Sex at Birth: M <input type="checkbox"/> F <input type="checkbox"/>	Current Sex: M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>	

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Address

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Enrolled in **another health plan**? Yes  No  **If yes, complete section 3.**

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

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Last Name	First Name	Social Security Number
Assigned Sex at Birth: M <input type="checkbox"/> F <input type="checkbox"/>	Current Sex: M <input type="checkbox"/> F <input type="checkbox"/> Other <input type="checkbox"/>	

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Address

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Enrolled in **another health plan**? Yes  No  **If yes, complete section 3.**

**SECTION 3: COORDINATION OF BENEFIT INFORMATION**

If you or a dependent are enrolled in **another health plan**, please provide the details of that coverage below and attach a copy of the 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.

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Print Name	Date
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Sign Name