ELECTRICIANS HEALTH & WELFARE PLAN
IBEW 995 ("Plan")

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2025 DEPENDENT ENROLLMENT FORM
(REQUIRED FOR COVERAGE)

"You" or "your" means an eligible employee. You are automatically covered by the Plan when you satisfy its eligibility requirements. *However, you must enroll your eligible dependents (spouse and children) during an enrollment period as a condition of their Plan coverage.* Enrollment is done by providing the information requested below and returning this form with the "***required documents***" to the Plan no later than the "***due date***" for the enrollment period. If you do *not* do so, you must wait until the next enrollment period to make enrollment elections or changes.

The "***due date***" for each type of enrollment period is described below. The "***required documents***" include a copy of the marriage license for an enrolled spouse, and birth certificates for enrolled children, if you have not already provided them to the Plan. Dependent children include your children under age 26, but not their spouse or children. A summary of the Plan's enrollment periods and related rules is included at the end of this form.

Every year during the Annual Enrollment Period, you may change your dependent enrollment instructions for the next year. If you take no action, your existing dependent enrollment instructions will continue in effect for the next year. If your dependents are currently enrolled but you do *not* want to enroll them for the next year, you must complete the "**Disenrollment Of Dependents In Medical Coverage"** section below and return it to the Plan no later than the "***due date***".

Check One: ___ ***Initial Enrollment Period*** ("***due date***" is 60th day after your dependent's initial eligibility, for coverage retroactive to initial eligibility);

___ ***Annual Enrollment Period*** for calendar year 20___ ("***due date***" is December 31 for coverage for the next calendar year);

___ ***Special Enrollment Period*** ("***due date***" is 60th day after the event giving rise to the Special Enrollment Period for coverage retroactive to such event).

YOU MUST COMPLETE THE FOLLOWING INFORMATION FOR EACH DEPENDENT (SPOUSE AND CHILD) YOU ARE ENROLLING IN THE PLAN:

1._____
Name Male or Female Social Security No. Date of Birth Relationship

_____
Address and Telephone Number (if different from yours)

2._____
Name Male or Female Social Security No. Date of Birth Relationship

_____
Address and Telephone Number (if different from yours)

3._____
Name Male or Female Social Security No. Date of Birth Relationship

_____
Address and Telephone Number (if different from yours)

4._____

Name | Male or Female | Social Security No. | Date of Birth | Relationship

_____

Address and Telephone Number (if different from yours)

5._____

Name | Male or Female | Social Security No. | Date of Birth | Relationship

_____

Address and Telephone Number (if different from yours)

If any above dependent being enrolled has Medicare, Medicaid or other group health insurance or coverage, you must list (1) *the effective date and type of each coverage*, (2) *the persons who are covered*, and (3) *the name/address of any employer through which the other coverage is provided*:

_____

_____

_____

DISENROLLMENT OF DEPENDENTS IN MEDICAL COVERAGE

Check and complete only as applicable.

I hereby elect to disenroll the following dependents in the Plan for the upcoming calendar year. I understand that any dependent spouse and child age 18 or older listed must sign below to acknowledge his/her disenrollment in the Plan. I understand this disenrollment election may only be changed during a subsequent annual or special enrollment period and that Plan coverage for the following dependents who are currently enrolled will end as of December 31 of the current calendar year or sooner if otherwise provided by Plan:

1._____

Name | Male or Female | Social Security No. | Date of Birth | Relationship

_____

Address and Telephone Number (if different from yours)

2._____

Name | Male or Female | Social Security No. | Date of Birth | Relationship

_____

Address and Telephone Number (if different from yours)

3._____

Name | Male or Female | Social Security No. | Date of Birth | Relationship

_____

Address and Telephone Number (if different from yours)

_____ _____

Dependent Spouse Accepting Disenrollment From Plan (Signature Required if Listed Above) **Date**

_____ _____

Dependent Child Age 18 or Older Accepting Disenrollment From Plan (Signature Required if Listed Above) **Date**

EMPLOYEE SIGNATURE REQUIRED. By signing below, I certify that the foregoing information is true and correct to the best of my knowledge. I confirm that I must inform the Plan immediately of any changes to this information. I understand that anyone who makes a false statement or representation of fact or fails to disclose a required fact may be subject to a fine or imprisonment.

Print Employee's Name **Employee's Signature**

Date Signed: _____

TO BE EFFECTIVE THIS COMPLETED FORM AND ANY "REQUIRED DOCUMENTS" MUST BE RETURNED TO PLAN NO LATER THAN THE "DUE DATE".

SUMMARY OF ENROLLMENT PERIODS: The Plan offers the following three enrollment periods:

Initial Enrollment Period: You have sixty (60) days after your dependent is first eligible to enroll him or her for coverage retroactive to the first day of eligibility. A dependent who is *not* timely enrolled will *not* be covered and will *not* be eligible for enrollment until the next Annual Enrollment Period or a Special Enrollment Period. The Plan will *not* verify coverage or pay claims or benefits until a Dependent is timely enrolled.

Annual Enrollment Period: An Annual Enrollment Period will be held each year, from November 1 through December 31, for dependent enrollment or disenrollment for the next calendar year. If you want to make dependent enrollment changes for the next calendar year, you must complete a new form and return it with the "*required documents*" to the Plan no later than December 31. Failure to do so will result in the continuation of your existing dependent enrollment instructions for the next calendar year.

Example: For 2024, you did *not* enroll your dependent spouse and child. If you do *not* complete and return a Dependent Enrollment Form (with the "*required documents*") to the Plan by December 31, 2024, your dependent spouse and child will *not* be enrolled/covered for the 2025 calendar year.

Special Enrollment Period: By law you may be eligible for a Special Enrollment Period: (1) if you acquire a new dependent because of birth, adoption, placement for adoption or marriage; or (2) if you previously did not enroll a dependent at initial eligibility (i) because he or she had other group health coverage and the other coverage ends due to loss of eligibility or because the employer stops contributing, or (ii) because it was COBRA coverage and the COBRA coverage is exhausted; or (3) if (i) you did not enroll a dependent because he or she had other coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and the other coverage ends, or (ii) your dependent becomes eligible for premium assistance through Medicaid or CHIP. You must notify the Plan within 60 days after any of these events, and if you qualify for special enrollment you may enroll the dependent in the Plan for coverage retroactive to such event.

NOTE: Refer to your Summary Plan Description booklet for additional Plan information or contact the Fund Office if you have questions.