

3. Is the above-named dependent currently married? Yes No
- A. If yes, is the above named dependent's spouse employed? Yes No
- B. If yes, where? _____
- C. If yes, is the above-named dependent eligible for coverage under his or her spouse's health plan (even if he or she has not enrolled)? Yes No
- D. If the dependent is not eligible to enroll under his or her spouse's health plan, why is he or she not eligible?

4. Is the above-referenced dependent covered, or eligible for coverage, under ANY OTHER health insurance plan?
Yes No
- A. If yes, please provide the name of the plan: _____
- B. If yes, is this the health plan of the above-referenced dependent's other parent's employer? Yes No

REQUESTED INFORMATION SECTION

Relationship to Member:

- Biological Child
- Legally Adopted Child
- Foster Child
- Grandchild
- Step Child

Required Documentation:

- Birth Certificate
- Legal Adoption Agreement
- Legal paperwork
- Birth Certificate, Order awarding full custody
- Birth Certificate, Spouse's Divorce Decree, Separation Request or Family Court Order stating custody and parent insurance responsibility.

DECLARATION

Please be advised that your dependent's spouse and children are not eligible for coverage under the New York State Teamsters Council Health & Hospital Fund Plan. Only individuals who have a parent-child relationship with the Participant, and who are not eligible for coverage under another health plan (other than the health plan of the other parent) are eligible for this enrollment opportunity. This means that only the biological children, step-children, adopted children, foster children and grandchildren (covered by a court order) of the Participant may qualify for coverage until age 26. **If you have children under the age of 26 who meet these requirements, and you wish to enroll them for coverage under the New York State Teamsters Council Health & Hospital Fund Plan you must complete this form for each eligible child and return it to the Fund Office at PO Box 4928, Syracuse, New York 13221-4928 within 30 days from their termination date. In the event you fail to submit the required documentation within the 30 day period following termination, your dependent will not be allowed to enroll until the following January open enrollment period.**

I attest and certify that the information provided in this Enrollment Form and Declaration is accurate and truthful. I understand that any person who knowingly makes a false statement with regard to a material fact shall not be entitled to receive the benefits claimed during the period. I further understand that if the Plan pays benefits for which it is not liable, as a result of any misstatement or omission contained herein, any amounts that the Plan overpays will be recovered directly from me.

Member's Signature: _____

Date: _____