April 1, 2011

Dear Member/Retiree

Re:  Extended Dependent(s) Health Care Coverage to Age 26 – Available on July 1, 2011

On September 23, 2010 President Obama signed into law the “Affordable Care Act” which requires benefit plans to cover dependent(s) up to age 26. Effective July 1, 2011, your dependent(s)’ (not their spouses or your dependent(s)’ children) will be eligible to be enrolled in the DC37 Health & Security Plan’s supplemental benefits (prescription drug, dental & optical) only:

- If your dependent(‘s) prior coverage ended (e.g. his/her coverage by DC 37, another health insurance policy or COBRA), or,

- If you never enrolled your dependent(s) in DC37 benefits or if your dependent(s) lost coverage because such coverage ended before s/he reached age 26, or,

- If your dependent(s) is/are not covered or eligible for coverage by his/her employer-sponsored health benefits (dental, prescription drugs, optical)

These health-related benefits will be available to your dependent(s) up to the end of the month in which he/s reaches the age of 26; regardless of whether or not: he/s lives at home, is declared as a dependent on your tax return, is in school, is employed (without benefits), or is married or unmarried.

You may enroll your dependent(s) using the form on the reverse side of this page. The completed form must be submitted to DC37 Health & Security Plan by June 1, 2011. Remember, coverage for your dependent(s) will not be effective until July 1, 2011.

To terminate your enrolled dependent(s) for DC37 Health & Security Plan benefits (for any reason including the fact that he/s has obtained health coverage through an employer), you may download the “Termination Form” from the website at www.dc37.net or call the Plan office at (212) 815-1234.

You are under an on-going obligation to timely update the information on this form, including, but not limited to, disclosing that your dependent(s) has/have obtained health coverage through his/her employer.

YOU ARE REQUIRED TO RETURN THE COMPLETED FORM ON THE OPPOSITE SIDE OF THIS PAGE FOR YOUR DEPENDENT(S) BETWEEN THE AGES OF 19-26 YEARS OLD!
District Council 37
Application Form for DC 37 Health & Security Plan Benefits only for Your Dependent(s) (between ages 19 – 26)

To be completed by Member/Retiree

Name: ___________________________/_________________________/_________________________

(Last) (First) (MI)

Member/Retiree PID Number: _________________ (OR) Social Security Number: ______-_____-_____

Agency/Department where you work: _____________________________Work Phone ______/____/_____

Home Address: _____________________________________________Apt#____ City: ________________ State: ___ Zip: _______

Home Phone_____/____/____Cell Phone_____/____/____Home E-Mail Address (Optional) __________________

Please check if your dependent(s) (age 19-26) is currently receiving Health & Security Plan benefits. Yes ☐ No ☐

If you checked “yes” you must provide the dependent(s) information below.

If you checked “no”, attach a copy of the birth certificate or adoption papers for the dependent(s) you wish to enroll. Your enrollment request cannot be processed until this documentation is provided.

Required Dependent(s) Information (To be completed by member/retiree) (Copy this form if enrolling more than one dependent).

Dependent’s Name: ___________________________/_________________________/_________________________

(Last) (First) (MI)

Dependent’s Social Security Number: ______/_____/_____

Date of Birth: ____/_____/_____

(Mo) (Day) (Year)

(Home Address: if different from Parent):

______________________________________________________________/_____/_____/____/

(Street Address) (Apt. #) (City) (State) (Zip)

Home Phone_____/____/____Cell Phone_____/____/____Home E-Mail Address (Optional) __________________

Relationship to Member/Retiree: Son ☐ Step- Son ☐ Daughter ☐ Step- Daughter ☐ Other ☐________

Is/are dependent(s) covered or eligible for coverage by his/her employer-sponsored health benefits (dental, prescription and optical)? Yes ☐ No ☐

If yes, list insurance company name & policy #: __________________

Intentional submission of erroneous information on this form may result in suspension of your DC37 Health & Security Plan benefits as well as denial of coverage for your dependent(s).

Member/Retiree Signature: ___________________________ Date: ___________________________

Return this completed form & supporting documentation to the DC 37 Health & Security Plan - 125 Barclay Street, Room 811 New York, NY 10007 Fax # (212) 815-1649 (Retain a copy for your files)