

CENTRAL LABORERS' WELFARE FUND ENROLLMENT/ADD/UPDATE FORM 2026

Participant/Employee Information

Name:			
Local No.	SSN:	Home Phone:	
Cell Phone:		E-mail:	
Current address:			
City:		State:	ZIP Code:
Date of Birth:		Gender:	
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated <input type="checkbox"/> Widowed			

Spouse Information, if Married (Please enclose a copy of your Marriage License if not on file)

Name:			
SSN:	Home Phone:	Cell Phone:	
E-mail:		Date of Birth:	Gender:
Current address, if different from Participant:			
City:		State:	ZIP Code:
Employed: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> No	Self Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Work Phone:
Employer Name:		Employer Address:	
City:		State:	ZIP Code:

Spouse's Other Insurance Information: (THIS MAY INCLUDE COVERAGE BY A PARENT)

(Please enclose a copy of the front and back of the cards)

Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Other/Medicare			
Policy Holder Name:			Effective Date:
Medical Carrier:	Group No.	ID No.	
Dental Carrier:	Group No.	ID No.	
Vision Carrier:	Group No.	ID No.	
Prescription Carrier:	Group No.	ID No.	
Other Carrier /Medicare:	Group No.	ID No.	

Adult Dependent – Age 19 until age 26 (Please enclose a copy of the dependent's Birth Certificate if not on file)

Name:		Relationship: (i.e.-Natural Child; Stepchild; Foster Child)	
SSN:	Home Phone:	Cell Phone:	
E-mail:		Date of Birth:	Gender:
Current address, if different from Participant:			
City:		State:	ZIP Code:
Employed: <input type="checkbox"/> Full Time <input type="checkbox"/> Part Time <input type="checkbox"/> No	Self-Employed: <input type="checkbox"/> Yes <input type="checkbox"/> No		Work Phone:
Employer Name:		Employer address:	
City:		State:	ZIP Code:

Adult Dependent's Other Insurance Information: (Please enclose a copy of the front and back of the cards)

Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Other/Medicare			
Policy Holder Name:			Effective Date:
Medical Carrier:	Group No.	ID No.	
Dental Carrier:	Group No.	ID No.	
Vision Carrier:	Group No.	ID No.	
Prescription Carrier:	Group No.	ID No.	
Other Carrier /Medicare:	Group No.	ID No.	

Dependent Age 0 until age 19 (Please enclose a copy of dependent's Birth Certificate if not on file)

Dependent Name:	Date of Birth:	
Gender:	SSN:	Home Phone:
Resides with Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, with whom does the dependent reside:	
Current address, if different from Participant:		
Dependent Relationship: (i.e.-Natural Child; Stepchild; Foster Child)		

Dependent Name:	Date of Birth:	
Gender:	SSN:	Home Phone:
Resides with Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, with whom does the dependent reside:	
Current address, if different from Participant:		
Dependent Relationship: (i.e.-Natural Child; Stepchild; Foster Child)		

Dependent's Other Insurance Information: (Please enclose a copy of the front and back of the cards)

Type of Coverage: <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Prescription <input type="checkbox"/> Other/Medicare
Policy Holder Name: _____ Effective Date: _____
Name of Dependent(s) covered by the Policies:
Medical Carrier: _____ Group No. _____ ID No. _____
Dental Carrier: _____ Group No. _____ ID No. _____
Vision Carrier: _____ Group No. _____ ID No. _____
Prescription Carrier: _____ Group No. _____ ID No. _____

IF YOU HAVE MORE DEPENDENTS, PLEASE PROVIDE THE REQUESTED INFORMATION FOR EACH ON A SEPARATE PIECE OF PAPER.

PLEASE REMEMBER:

- 1. INCLUDE A COPY OF YOUR MARRIAGE LICENSE/CERTIFICATE SHOWING PROOF OF LEGAL MARRIAGE IF YOU ARE ADDING A SPOUSE FOR THE FIRST TIME.**
- 2. INCLUDE A COPY OF A BIRTH CERTIFICATE OR LEGAL DOCUMENT SHOWING PROOF OF A DEPENDENT'S RELATIONSHIP TO YOU IF YOU ARE ADDING A DEPENDENT FOR THE FIRST TIME.**
- 3. INCLUDE A COPY OF THE CARDS FROM ANY OTHER INSURANCE COVERING YOU, YOUR SPOUSE OR DEPENDENT(S).**

PLEASE CONTACT THE FUND OFFICE WITH ANY QUESTIONS YOU MAY HAVE. CALL 1-800-252-6571.

READ THE FOLLOWING INFORMATION CAREFULLY AND THEN SIGN AND DATE THIS FORM IN THE SPACE PROVIDED ON THE NEXT PAGE.

I agree that this application is subject to acceptance by the Central Laborers' Welfare Fund (the Plan). I understand, that if I, and any of my dependents, are eligible to participate in the Plan, that the healthcare services available to me and/or my dependent will be subject to the exclusions, limitations, deductibles, co-payments, coinsurance and other conditions of the Summary Plan Description ("SPD") and in any amendment(s) to the SPD. I further understand that the contribution(s) necessary for me, and my dependents, to be eligible (or to maintain eligibility) under the Plan may be subject to change.

I understand that my eligibility and that of my dependent(s) may be subject to verification and may require additional documentation from me including items such as marriage license, divorce decree(s), birth certificate(s), death certificate(s), official documents and/or other information before I or my dependent(s) are added and eligible on any plan offered by Central Laborers' Welfare Fund. I understand that, should I fail to submit needed verification documentation within the timeframes required, eligibility for benefits on expenses incurred by my dependent(s) or me may be delayed in processing, denied payment until such information is provided or denied eligibility all together by Central Laborers' Welfare Fund.

I certify that all the information recorded in this application is true and correct to the best of my knowledge and belief. I understand that any misrepresentation, misstatement or omission ("incorrect information") made regarding this application, whether intentional or not, will be cause for rejection of this application. In the event that this application is approved before the incorrect information is discovered, such discovery may result in termination of my coverage under the Plan or that of my dependent(s) (if such incorrect information relates to my dependent(s)), and I may be required to reimburse the Plan. Termination of my coverage or that of my dependent(s) may be retroactive to the date of enrollment. I understand that if the terminated dependent(s) is/are a minor, then I or any other responsible parent or guardian will be required to reimburse the Plan for any and all sums expended on the dependent(s) minor's behalf for healthcare services, together with reasonable attorneys' fees and expenses incurred in collection of such sums.

I confirm that Central Laborers' Welfare Fund offered me the opportunity to enroll my dependent(s) who will be under the age of 26 years on or after January 1, 2026 or who is an unmarried dependent over age 26 and meets the definition of a disabled dependent and whose coverage was never initiated, ended or who was denied. I understand that the opportunity to enroll such a dependent must be done within the 31 days of my Open Enrollment period if that dependent's eligibility is to begin the first day of the plan year for which I am enrolling or the effective date of my eligibility, whichever is later. I further understand that, should all the required documents needed to confirm the eligibility of my dependent(s) is not received within the 31 days of my Open Enrollment period, the eligibility effective date of my dependent(s) will be the first day of the month following receipt of my Open Enrollment Form and all required documentation.

I confirm that Central Laborers' Welfare Fund informed me that my Plan has eliminated all lifetime and annual limits on the dollar value of essential health benefits under Section 1302(b) of the Patient Protection and Affordable Care Act and applicable regulations.

I confirm that the Plan informed me that it believes it is a "grandfathered health plan" under the Patient Protections and Affordable Care Act (the Act) and, as permitted by the Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that the Plan may not include certain consumer protections of the Act that apply to other plans, for example, the requirements for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Act, for example, the elimination of lifetime limits on benefits. I understand the Plan will notify me when certain other consumer protections are adopted.

I confirm that Central Laborers' Welfare Fund provided me specific contact information where I may obtain answers to questions regarding which protections apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status. The contact information included the Central Laborers' Welfare Fund at 1-800-252-6571, the Employee Benefits Security Administration, the U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This web site has a table summarizing which protections do and do not apply to grandfathered health plans.

I confirm that I understand I can elect to cease coverage for Vision, Hearing and/or Dental Benefits under the Welfare Fund for myself or my dependents even though such Benefits are provided at no additional cost to me. I also understand that, to cease any of these coverages, I will need to provide written notice to the Fund Office of my intention to cease coverage(s). Cessation of vision, hearing or dental coverage will be effective as of the first day of the following month after the Fund Office receives such notice from you.

I also confirm that I understand that if I previously elected to cease coverage for Vision, Hearing and/or Dental Benefits under the Welfare Fund, I may reinstate coverage by providing written notice to the Fund Office. I further understand that reinstatement of vision, hearing or dental coverage will be effective as of the first day of the month immediately following the date the Fund Office receives such written notice from you.

I understand that, in the event of a conflict between the wording in this application, the Open Enrollment materials and the Plan Document that governs the Plan, the Plan Document shall govern. I further understand that the Trustees reserve the right to amend, modify and terminate the Plan at any time.

Print Name of Participant:

Signature of Participant:

Date:

**PLEASE REVIEW THE FOLLOWING LIST OF REQUIRED DOCUMENTS,
WHICH MAY BE NEEDED BY THE PLAN IN ORDER TO CONFIRM A DEPENDENT'S
ELIGIBILITY. IF ANY OF THE LISTED CIRCUMSTANCES PERTAIN TO YOUR
PERSONAL SITUATION, PLEASE PROVIDE COPIES OF
THE INFORMATION REQUESTED.**

SITUATION	REQUIRED DOCUMENTS
BIOLOGICAL DEPENDENT (PARENTS MARRIED) (ANY AGE)	COPY OF THE DEPENDENT'S BIRTH CERTIFICATE
BIOLOGICAL DEPENDENT (PARENTS NEVER MARRIED) (ANY AGE)	COPY OF THE DEPENDENT'S CERTIFIED BIRTH CERTIFICATE, OR A FILED VOLUNTARY ACKNOWLEDGMENT OF PATERNITY OR LEGAL DOCUMENT SHOWING PARTICIPANT'S RESPONSIBILITY TO COVER.
LEGALLY ADOPTED OR PENDING ADOPTION (ANY AGE)	COPY OF ADOPTION PAPERS OR SWORN STATEMENT WITH DATE OF PLACEMENT
STEPCHILD (ANY AGE) OR BIOLOGICAL CHILD (PARENTS NOW DIVORCED)	COPY OF NATURAL PARENT'S DIVORCE DECREE. MUST BE A FILED COPY AND INCLUDE INFORMATION REGARDING HEALTHCARE BENEFIT RESPONSIBILITY.
DEPENDENT PLACED UNDER FOSTER CARE OR UNDER LEGAL GUARDIANSHIP (ANY AGE)	COPY OF DOCUMENT PLACING THE DEPENDENT IN THE PARTICIPANT'S HOME FOR FOSTER CARE OR LEGAL GUARDIANSHIP DOCUMENTS.
ADULT DEPENDENT (DISABLED)	A DEPENDENT CONFIRMATION FORM AND A STATEMENT, FROM A LICENSED PHYSICIAN OR A COURT DOCUMENT, CONFIRMING THE DEPENDENT'S DISABILITY
SPOUSE	COPY OF THE MARRIAGE CERTIFICATE AND YOUR SPOUSE'S OTHER INSURANCE CARDS (IF YOUR SPOUSE IS EMPLOYED FULL TIME AND INSURANCE IS OFFERED THROUGH THAT EMPLOYMENT, YOUR SPOUSE IS REQUIRED TO ENROLL IN THE EMPLOYER'S COMPARABLE PLAN UNLESS A PRIMARY COVERAGE WAIVER IS SUBMITTED AND APPROVED).
REMOVING SPOUSE, DEPENDENT/STEPCHILDREN DUE TO DIVORCE OR LEGAL SEPARATION	FILED COPY OF THE DIVORCE DECREE OR LEGAL SEPARATION PAPERS
TERMINATING SPOUSE OR DEPENDENT COVERAGE DUE TO DEATH	COPY OF THE DEATH CERTIFICATE

**QUESTIONS?
PLEASE CALL 1-800-252-6571**