CENTRAL LABORERS' WELFARE FUND
OPEN ENROLLMENT FORM 2027

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: ☐ Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed

Participant's Other Insurance Information (THIS MAY INCLUDE COVERAGE BY A PARENT OR SPOUSE)
(Coverage other than with Central Laborers' Welfare where you are the policyholder.)

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

Type of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____

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.

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:		

Employed: ☐ Full Time ☐ Part Time ☐ No	Self Employed: ☐ Yes ☐ 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: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____

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.

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 COVERAGE ON YOU, YOUR SPOUSE OR DEPENDENT(S).**

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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:		
Employed: ☐ Full Time ☐ Part Time ☐ No	Self-Employed: ☐ Yes ☐ 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: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____		
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:		
Employed: ☐ Full Time ☐ Part Time ☐ No	Self-Employed: ☐ Yes ☐ 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: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____		
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 the dependent's Birth Certificate if not on file.)		
Dependent Name:	Date of Birth:	
Gender:	SSN:	Home Phone:
Resides with Participant: ☐ Yes ☐ 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: ☐ Yes ☐ No	If no, with whom does the dependent reside:	
Current address, if different from Participant:		
Dependent Relationship: (i.e.-Natural Child; Stepchild; Foster Child)		

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Dependent age 0 until age 19 (Continued)		
Dependent Name:	Date of Birth:	
Gender:	SSN:	Home Phone:
Resides with Participant: ☐ Yes ☐ 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: ☐ Yes ☐ 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: ☐ Yes ☐ 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: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____		
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.

Dependent's Other Insurance Information: (Please enclose a copy of the front and back of the cards.)		
Type of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription ☐ Medicare ☐ Other _____		
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.

DEATH BENEFIT BENEFICIARY INFORMATION

COMPLETE THE FOLLOWING SECTION IF YOU ARE A PARTICIPANT NOT COVERED BY COBRA OR A RETIREE PLAN. BE SURE YOU SIGN AND DATE THE BENEFICIARY ELECTION.

PRIMARY DEATH BENEFICIARY:		
Beneficiary Name:		Relationship:
Beneficiary Address:		
Beneficiary City:	Beneficiary State:	Beneficiary ZIP code:

ALTERNATE BENEFICIARY IF PRIMARY BENEFICIARY PRE-DECEASES ME:		
Beneficiary Name:		Relationship:
Beneficiary Address:		
Beneficiary City:	Beneficiary State:	Beneficiary ZIP code:
Signature of the Participant:		Date:

USE MY ALTERNATE BENEFICIARY IF I AM DIVORCED FROM THE PRIMARY BENEFICIARY. ☐ Yes ☐ No

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PLEASE SELECT YOUR 2027 ENROLLMENT STATUS FOR THE BLUECROSS/BLUESHIELD BLUE CHOICE OPTIONS PLAN

☐ Open Enrollment - Active ☐ Open Enrollment - Retiree ☐ Open Enrollment - COBRA

READ THE FOLLOWING INFORMATION CAREFULLY AND THEN SIGN AND DATE THIS FORM IN THE SPACE PROVIDED

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 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, 2027, 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 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) not be 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 website 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:**