LOCAL 138, 138A, 138B & 138C, I.U.O.E. WELFARE FUND

AFFIDAVIT OF AVAILABLE HEALTH COVERAGE
FOR DEPENDENT THROUGH AGE 26

This Affidavit Must Be Completed Separately For Each Eligible Dependent

Additional Affidavits are Available for Download at www.local138.com (Welfare Fund, Downloads)

I. PARTICIPANT INFORMATION

Participant Name: Social Security No.:

_____ _____

Address: _____

_____

II. DEPENDENT'S INFORMATION

Dependent's Name: Social Security No.:

_____ _____

Dependent's Date of Birth*:

_____

*A copy of each dependent's birth certificate and a photostat copy of each dependent's social security card must be provided with this Affidavit.

Address: _____

_____

III. DEPENDENT'S OTHER COVERAGE INFORMATION

Do you have medical and prescription drug coverage options available through your own employer?

❑ YES ❑ NO If NO, please complete the signature section below and return to the Fund Office in the envelope provided.

If YES, please provide the following information:

EMPLOYER'S NAME:

_____

EMPLOYER'S ADDRESS:

_____

EMPLOYER'S TELEPHONE NUMBER:

_____

(CONTINUED ON REVERSE SIDE)

NAME OF EMPLOYER'S GROUP HEALTH PLAN/INSURANCE COMPANY

_____

POLICY/ID NUMBER:

_____

ADDRESS OF EMPLOYER'S GROUP HEALTH PLAN/INSURANCE COMPANY

_____

INSURED'S NAME:

_____

EFFECTIVE DATE OF COVERAGE:

_____

IV. SIGNATURE SECTION

The undersigned, declare jointly and severally that the above information is true and complete. The undersigned acknowledge that making a material misstatement of fact or concealing any pertinent information herein shall entitle the Fund to pursue any action against the Participant and/or the Participant's Dependent, to the maximum extent permitted under law, including but not limited to, the reimbursement of any claims paid on behalf of the Dependent and/or criminal prosecution. The Participant agrees to immediately notify the Fund if the Dependent obtains alternative health coverage in the future.

DATE:_____

SIGNATURE OF DEPENDENT:) ss:

STATE OF _____

COUNTY OF

On this day of _____ , 2011, before me personally came _____ and _____ known to me to be the individuals described herein by providing appropriate identification and who executed the foregoing **AFFIDAVIT OF AVAILABLE HEALTH COVERAGE FOR CHILDREN THROUGH AGE 26 and having duly** acknowledged to me that he/she executed the same.

_____
Notary Public

SIGNATURE OF PARTICIPANT: _____ DATE: _____

STATE OF _____)
) ss:
COUNTY OF _____)

On this day of _____ , 2011, before me personally came _____ and _____ known to me to be the individuals described herein by providing appropriate identification and who executed the foregoing **AFFIDAVIT OF AVAILABLE HEALTH COVERAGE FOR CHILDREN THROUGH AGE 26** and having duly acknowledged to me that he/she executed the same.

_____
Notary Public

ENCLOSURE
Copy of Child's Birth Certificate
Photostat Copy of Child's Social Security Card

Please return to the Local 138, 138A, 138B & 138C , I.U.O.E. Welfare Fund, P.O. Box 206, 137 Gazza Boulevard, Farmingdale, NY 11735