Fox Valley & Vicinity Construction Workers Welfare Fund

915 National Pkwy, Suite F, Schaumburg, IL 60173 Toll Free 800-249-7947 Fax 847-519-1979

Dear Participant:

This acknowledges you have a dependant over age 19 who may be employed. If the dependent below is employed, the participant and Employer are required to provide the following information and include a signature. If the dependent is not employed complete participant section and return to the Fund office.

To be completed by Participant:

Dependant's Name: _____ Date of Birth: _____

Member's name: _____ Member's SS#: _____

Dependant's relationship to member: _____

Is the dependant employed? Yes: ____ No: ____

Was dependant employed from June 2011 to current by same Employer? Yes:____ No: _____

If No, who was prior Employer and was insurance offered? _____

_____

To be completed by Employer:

Name, address, and telephone number of Employer;

_____

_____

Regardless of whether the Dependent named above elected coverage, is/was the Dependent eligible for group health coverage through the Dependents Employer? Yes_____ No _____

Authorized Signature_____ Date_____

We understand that dependent healthcare coverage under the Fox Valley & Vicinity Construction Workers Welfare Fund for dependent children up to age 26 is only available if the dependent child is NOT eligible for healthcare coverage at his/her place of employment. We understand that we are responsible for notifying the Fund Office of changes in the child's employment and/or changes in eligibility for coverage under this Plan within 30 days of the change. We understand and agree that failure to notify the Fund office of these changes as set forth in this verification may result in the denial of healthcare claims under this Plan or pursuit by the Fund office for reimbursement for benefits inappropriately received.

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS CORRECT TO THE BEST OF MY KNOWLEDGE AND AUTHORIZE RELEASE OF ANY INFORMATION REQUESTED WITH RESPECT TO VERIFICATION OF THIS INFORMATION.

Signature of Participant: _____ Date: _____

Signature of Dependent: _____ Date:_____