SAN FRANCISCO ELECTRICAL WORKERS HEALTH & WELFARE PLAN

720 MARKET ST., STE. 700
SAN FRANCISCO, CA 94102
Ph. (415) 263-3670 Fx. (415) 263-3672

An Adult Child age 19 through 25 may be eligible for coverage on the same basis as dependent children under the Plan.

SECTION 4: ADULT CHILD (Age 19 through Age 25) ENROLLMENT INFORMATION						
Adult Child			Birth Date		Soc. Sec. No.	
Adult Child Address						
Is this adult child employed? ☐ Yes ☐ No	If Yes, Provide Name and Address of Employer:					
Does this adult child have medical insurance available (even if not elected) through his/her employment? ☐ Yes ☐ No	If Yes: Name/Address of Insurance					
	Phone No.		Policy No.		Effective Date	
Is other Medical Insurance available through a Parent other than the above named Participant? ☐ Yes ☐ No	If Yes: Parent's Name				Soc. Sec. No.	
	Name/Address of Insurance					
	Phone No.		Policy No.		Effective Date	
Is other Medical Insurance available (even if not elected) through the spouse of the Adult Child? ☐ Yes ☐ No ☐ Not Married	If Yes: Spouse's Name				Soc. Sec. No.	
	Name/Address of Insurance					
	Phone No.		Policy No.		Effective Date	

(A Separate Form Must Be Completed For Each Adult Child Enrollment Request)

PARTICIPANT CERTIFICATION REQUIRED TO REQUEST COVERAGE		
I certify the accuracy of the above information and choose to elect coverage on the indicated Adult Child. I understand that I must inform the Plan Office of any changes in Adult Dependent Status. In understand that I will be responsible for any overpayments that occur if a status change occurs and the Plan Office is not notified.		
Participant Name (Print):	Date:	Phone:
Participant Signature:		Participant SSN: