**DISTRICT NO. 9, I. A. OF M. & A. W. WELFARE TRUST**
12365 St. Charles Rock Road ■ Bridgeton, MO 63044
(314) 739-6442 ■ (888) 739-6442 ■ fax (314) 739-2374 ■ www.d9trusts.org

# ADULT CHILD ELIGIBILITY FORM FOR COVERAGE

This form must be completed for each adult child upon turning age 19 or when first enrolled and each calendar year thereafter.

**It is important for the continued coverage that we be informed of any changes in this information.**

## Member Information

| Last Name: | First: | Middle Initial: | Member ID# (Found on Insurance Card): |
|---|---|---|---|
| | | | |

| Home Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

## Adult Child Information

| Last Name: | First: | Middle Initial: | Social Security #: |
|---|---|---|---|
| | | | |

| Home Address: | City: | State: | Zip: |
|---|---|---|---|
| | | | |

| Marital Status: | Date of Birth: | Phone Number: |
|---|---|---|
| ○ Single ○ Married ○ Widowed ○ Divorced ○ Legally Separated | | |

## Other Insurance Information - You must include a copy of all other medical, Medicare and/or dental insurance card(s).

| Are you employed? ○ No ○ Yes | Employer Name: | Employer Phone: |
|---|---|---|
| | | |

I have the following benefits through my own employment (check all that apply): ☐ Medical ☐ Dental ☐ No Benefits

| If Yes, is there a HRA, FSA or HSA with this coverage? ○ No ○ Yes | Do you have Medicare? ○ No ○ Yes | Medical Effective Date: | Dental Effective Date: |
|---|---|---|---|
| | | | |

➢ If married, do you have coverage through your own spouses' employer? ○ No, skip this section ○ Yes, complete this section

**If Yes**, is there a HRA, FSA or HSA with this coverage? ○ No ○ Yes

| Spouse's Name: | Birth Month/Day Only: | Medical Effective Date: | Dental Effective Date: |
|---|---|---|---|
| | | | |

➢ Do you have coverage through a parent/step-parent - other than this plan? ○ No, skip this section ○ Yes, complete this section

**If Yes**, is there a HRA, FSA or HSA with this coverage? ○ No ○ Yes

| Parent's Name: | Birth Month/Day Only: | Medical Effective Date: | Dental Effective Date: |
|---|---|---|---|
| | | | |
| Parent's Name: | Birth Month/Day Only: | Medical Effective Date: | Dental Effective Date: |
| | | | |
| Step-Parent's Name: | Birth Month/Day Only: | Medical Effective Date: | Dental Effective Date: |
| | | | |
| Step-Parent's Name: | Birth Month/Day Only: | Medical Effective Date: | Dental Effective Date: |
| | | | |

I certify that:

- The listed Adult Child is eligible for coverage under the terms of the District No. 9, International Association of Machinists & Aerospace Workers Welfare Plan.
- The information provided above is correct to the best of my knowledge, and I authorize the release of any information requested to the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan.

I understand that the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan will, from time to time, require updated certification, and that I must notify the Fund Office immediately of any change in my status as an Adult Child or of any change in eligibility for health coverage under any other medical insurance or self-insured plan, including that of an employer.

**Signature of Member:** _____ Date: _____

I certify that:

- I have reviewed the information contained on this form and that it is true and accurate.
- I will notify the above named Member in the event that I become eligible for coverage under any other employer sponsored health insurance or self-insured plan.

I understand that the District No. 9, International Association of Machinists and Aerospace Workers Welfare Plan will, from time to time, require updated certification, and that I must notify the Fund Office immediately of any change in my status as an Adult Child or of any change in eligibility for health coverage under any other medical insurance or self-insured plan, including that of an employer.

**Signature of Adult Child**: _____ Date: _____