THE HAWAII ELECTRICIANS HEALTH AND WELFARE FUND

Special Enrollment Form For Extension of Coverage For Adult Children Up To Age 26

Employee Information:

Last Name	First Name	Middle Initial (MI)

Mailing Address	Social Security Number (SSN) – **REQUIRED**

City	State	Zip code

Gender	Date of Birth (DOB) (Month/Day/Year)	Are you currently enrolled in the Plan?	Home Phone number	Cell/Phone number
☐ F ☐ M		☐ Yes ☐ No (if no, you must enroll yourself in order to cover your dependent children)		

Dependent Child Enrollment: Complete this section for **each** dependent child you wish to enroll (add) for coverage.

Last Name	First Name	MI	Gender	DOB	Soc Sec No (SSN) – Submit Copy-REQUIRED
			☐ F ☐ M		
			☐ F ☐ M		
			☐ F ☐ M		

***Relation to Participant:** means Son, Daughter, Stepson, Stepdaughter, Adopted child. You must provide valid supporting documentation of child's relation, such as a copy of the child's birth certificate, marriage certificate of parents, etc.

Employment Information: Are you currently employed over 20 hours a week? ☐ Yes ☐ No

Other Health Care Coverage Information:

Complete the following section if your dependent child(ren) is ***currently*** covered for medical care under another group health coverage either through his/her own employment, his/her own spouse or through the other parent.

Policyholder's Name:	Policyholder relationship to Child ☐ Self ☐ Parent ☐ Child's spouse	Policyholder DOB:	Group and Policy #:

Insurance Company (Submit copy of Card)	Address:	Phone #:

Employer Name/ Address and Phone Number:

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that if I defraud, conceal or provide false information for the purpose of misleading the Fund, my child's eligibility for Fund coverage will be terminated and I will be liable for any claims that were paid erroneously based on the false or misleading information.

Signature________________________________ **Date**____________________