

Mo-Kan Sheet Metal Workers Welfare Fund
P.O. Box 300019
Kansas City, MO 64130-0019
(816) 531-0334 or Toll Free at (866) 531-5488



Notice of Opportunity to Enroll in connection with Extension of Dependent Coverage to Age 26

****Original Mail Date - November 1, 2010**

Dear Member:

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Mo-Kan Sheet Metal Workers Welfare Fund. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective **January 01, 2011** for all dependents who qualify based on the guidelines set forth by the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2011. If you have a qualifying dependent and wish to add them to your current policy, you must complete the attached document and return it no later than **December 15, 2010**. If you do not add your eligible dependent during this 30 day period, in order to add that dependent in the future the dependent will have to have had a qualifying event to join the plan.

Please note – If you have a dependent over the age of 19 who is actively covered under the plan as of the date of this notice, there is no need to complete and return the attached forms.

For more information or questions about this notice, please contact the Fund office at 816-531-0334, ext. 108 or toll-free at 866-531-5488, ext 108.

Thank you.

Dependent Coverage Add/Change Form



I. MEMBER INFORMATION

Name of Member (Last) _____ (First) _____ (M.I.) _____ Date of Birth / / Social Security Number - -

Street Address _____ City _____ State _____ Zip Code _____ Telephone # _____

Local Number _____ Employer _____

II. DEPENDENT INFORMATION

ADD / CHANGE DEPENDENT INFORMATION

Please include a copy of any court document, such as a divorce decree or QMCSO that pertains to medical coverage for your dependent(s).

	Dependent	Dependent	Dependent
Last Name			
First Name			
Date of Birth	___/___/___	___/___/___	___/___/___
Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Male <input type="checkbox"/> Female
Relationship to Member	<input type="checkbox"/> Dependent Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Guardian Child	<input type="checkbox"/> Dependent Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Guardian Child	<input type="checkbox"/> Dependent Child <input type="checkbox"/> Step-Child <input type="checkbox"/> Guardian Child
Social Security Number	___-__-__	___-__-__	___-__-__
Address (if different from member)			
Are you employed?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your employer offer insurance coverage? <i>If yes, complete Section III.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A
Are you enrolled or eligible to enroll in an eligible employer-sponsored health plan, other than a group health plan of a parent? <i>If yes, complete Section III</i>	<u>Check One</u> <input type="checkbox"/> No. <input type="checkbox"/> Yes. Complete Section III.	<u>Check One</u> <input type="checkbox"/> No. <input type="checkbox"/> Yes. Complete Section III.	<u>Check One</u> <input type="checkbox"/> No. <input type="checkbox"/> Yes. Complete Section III.

Signature: _____ Date: _____

Other Insurance Verification Form

III. Other Insurance Coverage Information

Employer Name: _____

Phone Number (____) _____

Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Hire Date: _____ Current Position: _____

My employer does not offer health insurance coverage at this time. (Skip to the bottom to sign and date)

Name of Other Insurance: _____

Address of Other Insurance: _____

City: _____ State: _____ Zip Code: _____

Phone Number of Other Insurance: (____) _____ Policy Number (as it appears on the card): _____

Group Number: _____ Effective Date: _____

Coverage Includes (check all that apply):

<input type="checkbox"/> Medical & Prescription Drug.....	<input type="checkbox"/> Employee Only.....	<input type="checkbox"/> Family
<input type="checkbox"/> Vision.....	<input type="checkbox"/> Employee Only.....	<input type="checkbox"/> Family
<input type="checkbox"/> Dental.....	<input type="checkbox"/> Employee Only.....	<input type="checkbox"/> Family

I hereby certify that all the information in this section is accurate and complete to the best of my knowledge. I hereby authorize my employer to release information regarding my employer's health insurance plan and my eligibility for coverage under that plan to the Fund. I understand this authorization remains in effect as long as I am eligible for benefits under the Fund. I understand the purpose and scope of this authorization is to allow the Fund to verify with my employer whether I am eligible to collect or obtain coverage under my employer's health plan.

I also understand that if my employment status or the availability for insurance coverage through my employment changes, it is my responsibility to notify the Fund office immediately.

Signature: _____ Date: _____