DIVISION 1181 A.T.U. – NEW YORK WELFARE FUND
101-49 Woodhaven Boulevard, Ozone Park, N.Y. 11416
(718) 845-5800

COVERAGE UP TO AGE 26 FOR DEPENDENTS - NEW ENROLLMENT OPPORTUNITY

Dear Participant:

As a result of the federal health care reform law called the Patient Protection and Affordable Health Care Act (PPACA), effective January 1, 2011, the Fund has extended coverage to biological children, adopted children, children placed with you for adoption, stepchildren, and children over whom you have a guardianship right until the end of the month in which they become 26, unless the dependent child is eligible for employer-sponsored health coverage from a plan other than that of the dependent's parent (such as through the dependent's employment or through his spouse's employment). The rules have not changed for foster children and disabled children. Therefore, the current conditions on dependent coverage (i.e., dependent must be unmarried, must be dependent on you for support, resides with you in a parent-child relationship, etc.) only apply to foster children, and not to any other category of child. Please contact the Fund Office if you have any questions on these rules.

If you have an eligible dependent child under age 26 who is not currently enrolled in the Fund, you may now enroll the child for coverage during this Open Enrollment period that will run until January 31, 2013. If you complete and submit the enclosed forms timely, along with a copy of your child's birth certificate and any other documentation proving their age and relationship to you, the dependent child's coverage will begin February 1, 2013. If your documentation is received after the end of Open Enrollment, coverage will be effective on the first day of the month following the month in which the Fund office receives your properly completed enrollment documents, unless you are entitled to a different effective date under the HIPAA special enrollment rules set forth in your SPD.

As stated above, the Fund will now exclude coverage for all dependent children between ages 19 - 26 if the child is eligible to enroll in an employer-sponsored plan other than the plan of his/her parent. That means if your child is between ages 19- 26 and is eligible for other employer-sponsored health plan coverage through his/her own employment or through his/her spouse's employment (even if he or she did not enroll for it), he or she is not eligible to enroll for dependent coverage under the Fund. If your age 19-26 dependent child is not eligible for coverage due to the above exclusion, but is a full-time student at an accredited school per the Fund's current rules, the adult child will still be eligible for coverage until the calendar year in which he or she attains age 23, assuming you submit appropriate documentation of full-time status to the Fund Office.

Failure to complete all information requested may result in a delay of your dependent's eligibility for coverage. **If you are enrolling an adult child between ages 19-26, the adult child and the adult child's spouse (if applicable) must sign these forms where indicated for them to be valid.** Please call the Fund Office at 718-845-5800 if you have any question.

Very truly yours,

Fund Office

Notice of Grandfathered Status

The Division 1181 A.T.U. – New York Welfare Fund believes that both its Active and Retiree Plans are "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, effective January 1, 2011, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits, unless a waiver applies.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator as set forth below. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Notice of Early Retiree Reinsurance Program Participation

You are a plan participant, or are being offered the opportunity to enroll as a plan participant, in an employment-based health plan that is certified for participation in the Early Retiree Reinsurance Program. The Early Retiree Reinsurance Program is a Federal program that was established under the Affordable Care Act. Under the Early Retiree Reinsurance Program, the Federal government reimburses a plan sponsor of an employment-based health plan for some of the costs of health care benefits paid on behalf of, or by, early retirees and certain family members of early retirees participating in the employment-based plan. By law, the program expires on January 1, 2014.

Under the Early Retiree Reinsurance Program, your plan sponsor may choose to use any reimbursements it receives from this program to reduce or offset increases in plan participants' premium contributions, co-payments, deductibles, co-insurance, or other out-of-pocket costs. If the plan sponsor chooses to use the Early Retiree Reinsurance Program reimbursements in this way, you, as a plan participant, may experience changes that may be advantageous to you, in your health plan coverage terms and conditions, for so long as the reimbursements under this program are available and this plan sponsor chooses to use the reimbursements for this purpose. A plan sponsor may also use the Early Retiree Reinsurance Program reimbursements to reduce or offset increases in its own costs for maintaining your health benefits coverage, which may increase the likelihood that it will continue to offer health benefits coverage to its retirees and employees and their families.

LIST BELOW THE NAME(S) OF YOUR DEPENDENT CHILDREN FOR WHOM YOU REQUEST COVERAGE.
A COPY OF THE MARRIAGE CERTIFICATE/BIRTH CERTIFICATE/ADOPTION PAPERS, ETC. MUST BE INCLUDED WITH THIS APPLICATION TO PROPERLY ENROLL THE DEPENDENT. WRITE "N/A" IN ANY FIELD THAT DOES NOT APPLY.
FORMS WITH INCOMPLETE FIELDS WILL BE RETURNED, WHICH MAY RESULT IN A DELAY OF COVERAGE THROUGH THIS FUND.

Employee Information:

Last Name	First Name	Middle Initial (MI)
Mailing Address		Social Security Number
City	State	Zip Code
Gender F M / Date of Birth: (Month/Day/Year)	Home Phone Number	Cell Phone Number

LIST NAMES IN ORDER OF AGE – ELDEST FIRST	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER	IS DEPENDENT CHILD ENROLLED IN ANY OTHER HEALTH CARE COVERAGE? IF YES PROVIDE A COPY OF THE INSURANCE CARD, NAME OF INSURER, AND EFFECTIVE DATE OF COVERAGE	IS YOUR AGE 19-26 DEPENDENT CHILD ELIGIBLE FOR ANY HEALTH CARE COVERAGE THROUGH HIS/HER EMPLOYER? If YES, provide Employer information, including Human Resource contact information	IS YOUR AGE 19-26 DEPENDENT CHILD'S SPOUSE ELIGIBLE FOR HEALTH CARE COVERAGE THROUGH HIS/HER EMPLOYER? If YES, provide Employer information, including Human Resource contact information.	IS CHILD ENROLLED AS A FULL-TIME STUDENT? IF YES, PROVIDE A COPY OF THE DOCUMENT FROM SCHOOL.

Once you have completed the form, please complete the next page (if applicable) and have you, your adult child (and his or her spouse, if married) sign and date the Statements on the following page.

Employer Name/Address and Phone number: If your adult child age 19-26 is employed, provide employer name, address and phone number. If the child is married and the spouse is employed, provide information about the spouse's employer. If you need more entries, please write additional information in the space provided below.

Dependent:	Employer's Name, Address, Phone #:
Dependent:	Employer's Name, Address, Phone #:
Dependent's Spouse:	Employer's Name, Address, Phone #:
Dependent's Spouse:	Employer's Name, Address, Phone #:

Eligibility for Other Health Care Coverage: Complete the following section if your dependent child is currently ***enrolled for*** coverage under any other Plan. The Fund must have this information for Coordination of Benefits purposes. If you need more entries, please write additional information in the space provided below.

Dependent's Name:	Policyholder's Name and Relationship to Child:	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:	Address:		Phone #:
Dependent's Name:	Policyholder's Name and Relationship to Child:	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:	Address:		Phone #:
Dependent's Name:	Policyholder's Name and Relationship to Child:	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:	Address:		Phone #:
Dependent's Name:	Policyholder's Name and Relationship to Child:	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:	Address:		Phone #:

Employee Statement: I acknowledge by signing this form that all the information provided is true, complete and correct to the best of my knowledge. I have read and understand the Fund's plan eligibility requirements. I understand that if I withhold information, provide incorrect information, or mislead the Fund, my child's eligibility for Fund coverage will be terminated retroactively and I will be liable for any claims that were paid erroneously based on the false or misleading information. I understand that I have a duty to notify the Fund no later than 30 days of any changes that affect the eligibility of any of my covered dependents; for example, divorce or ceasing to meet the dependent eligibility requirements set forth above.

Signature_____ Date_____

***If you are enrolling an adult child between ages 19 -26, he or she must sign the Statement below.**

Adult Child's Statement: I acknowledge by signing this form that all the information provided is true, complete and correct to the best of my knowledge. I have read and understand the Fund's plan eligibility requirements. I authorize the Fund Office to contact my employer to verify the existence of other coverage that may be available to me through that employment. I understand that if I withhold information, provide incorrect information, or mislead the Plan, my eligibility for Fund coverage will be terminated retroactively and I and my parent will be liable for any claims that were paid erroneously based on the incorrect or misleading information. I understand that I have a duty to notify the Fund no later than 30 days of any changes that affect my eligibility for coverage.

Signature_____ Date_____

***If you are enrolling an adult child between ages 19 -26, and he or she has a spouse, the spouse must sign the Statement below.**

Adult Child's Spouse's Statement (if applicable): I acknowledge by signing this form that all the information provided is true, complete and correct to the best of my knowledge. I authorize the Fund Office to contact my employer to verify the existence of other coverage that may be available to my spouse through my employment. I understand that if I withhold information, provide incorrect information, or mislead the Fund, I, my spouse and his/her parent will be liable for any claims that were paid erroneously based on the false or misleading information.

Signature_____ Date_____