GCC/IBT LOCAL 14-M HEALTH AND WELFARE PLAN **ENROLLMENT/CHANGE FORM**

(Please print clearly and sign page 2)

Add/Remove Dependent

New Enrollment

Open Enrollment (1/1)	
I. SSN: Last Name: Date	Date of Birth:
State: Zip: Gender (M/F):	Gender (M/F):
II: Home Phone: Job Title:	Cell Phone:
III. COVERAGE AVAILABLE (90 days from date of hire): Medical (Aetna HMO); Rx (BeneCard); Dental (Delta Dental); Vision (Dental (Delta Dental); Vision (NVA)
	ore choosing one.)
Weekly Payroll Deduction - ☐ Single - \$64.60 ☐ 2 Party - \$82.34 ☐ 3 Party or more - \$90.43	,000/Other \$2,000 e - \$90.43
Plan B Deductible - \$2,500 Single/ \$5,000 Other Maximum Out of Pocket (MOOP): Medical - Single \$5,850/Other \$11,700; Rx - Single \$1,000/Other \$2,000 Weekly Payroll Deduction - □ Single - \$39.53 □ 2 Party - \$50.38 □ 3 Party or more - \$55.33	1,000/Other \$2,000 e - \$55.33
Check Coverage Level: ☐ Employee ☐ Employee + Spouse ☐ Employee + Child ☐ Employee + Children ☐ Family	ree + Children □ Family
IV. ADD DEPENDENT* - EFFECTIVE DATE: (check reason below)	
 ☐ Marriage (must provide copy of Marriage License) ☐ Birth of Child (must provide copy of Birth Certificate) 	
☐ Loss of insurance coverage (Must provide proof of loss of coverage)	
☐ Open Enrollment (JANUARY 1 ST ONLY)	
☐ REMOVE DEPENDENT - EFFECTIVE DATE:	of of other coverage]) (provide the following
*NOTE: Your eligible dependent includes your spouse or your children from birth to the end of the month they turn 26. Your adult dependents are <u>not</u> required to live with you, to depend on you for support, to be unmarried, or to maintain full-time student status.	ney turn 26. Your adult dependents are <u>not</u> required to live wit

IMPORTANT - Any newly acquired dependents (marriage, birth of child, adoption, etc.) are eligible for coverage under the Plan on the date they are acquired, provided that you furnish a completed application to the Plan Administrator within 30 days following the event. You must also provide a marriage certificate if adding a child, adopted child or newborn. If the Enrollment/Change Form is not received within 30 days following the event, changes will not be accepted

until the Plan's Open Enrollment period. Also, you may only change your coverage at the Plan's Open Enrollment period unless a "Life Event" occurs.

<u> </u>) e	3SE	V. Please complete the following information regarding yourself and/or your dependents.	formation I	regarding yourself an	id/or your	dependents.		
Add	Remove	Continue	Name (Include last name if different from Applicant) (PLEASE PRINT)	Name Name if different from	m Applicant)	Gender	Date	Social	Primary Care Physician (name & telephone number)
			Last		First	(M/F)	of Birth	(Mandatory)	[Must provide or Aetna will choose one for you.]
			Self						
			Spouse						
			Child						
	-		Child						
			Child						
^			Child						
(if)th	္က က	VI. Other Medical Insurance?No **(if "yes", please provide: Insurance Carrier:	No Carrier:	Yes	_ Effective Date:	e Date:	Member ID #:	Policy#:
					IMPORTANT NOTICE REGARDING FRAUDULENT INFORMATION	REGARDI	NG FRAUDULE	NT INFORMATION	
Any cont and	per: ainii sub,	son jeca	Any person who knowingly, and with intent to injure, defraud or deceive any insurance company or other person, containing any materially false information or conceals, for the purpose of misleading, information concerning ar and subjects such person to criminal and civil penalties.	to injure, defi or conceals, civil penalties	aud or deceive any insur for the purpose of mislea `.	ance compa ding, inform	any or other perso nation concerning	on, submits this Enrollmen any fact material thereto	Any person who knowingly, and with intent to injure, defraud or deceive any insurance company or other person, submits this Enrollment/Change Form for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information conceming any fact material thereto, commits a fraudulent insurance act which is a crime and subjects such person to criminal and civil penalties.
				13.	AUTHORIZATION FOR WEEKLY DEDUCTION OF DELINQUENT CO-PAY	VEEKLY DI	EDUCTION OF D	ELINQUENT CO-PAY	
The amo or la than	yoff \$20	ers reg for	signed hereby authorizes and re pularly deducted and forwarded which benefit coverage was pu per week. The undersigned h	quests his/he to the Fund I rovided by th ereby release	r Employer to deduct an by the Employer. Such c e Fund. The amount of a s and agrees to indemni	additional a leduction w additional w fy the Empl	mount per week t ill begin with the I eekly deduction : oyer from and ag	o be determined as set fo bay period in which the u shall be based on five pe sinst any and all claims n	The undersigned hereby authonizes and requests his/her Employer to deduct an additional amount per week to be determined as set forth below in addition to the participant weekly co-pay amount regularly deducted and forwarded to the Fund by the Employer. Such deduction will begin with the pay period in which the undersigned returns from a medical leave of absence or layoff for which benefit coverage was provided by the Fund. The amount of additional weekly deduction shall be based on five percent (5%) of weekly net pay and in no case be less than \$20.00 per week. The undersigned hereby releases and agrees to indemnify the Employer from and against any and all claims made against the Employer by virtue of said payment.
≦	Me	ž	VII. Member Signature:				_ Date Signed:		
Retu	<u> </u>	o'	Return Form To Benefits Administrator:	Margie M. Horton Fax: 215.773.9907 Email: <u>mhorton@r</u>	Margie M. Horton Fax: 215.773.9907 Email: <u>mhorton@rgabriel.com</u>	т о =.	richard Gabriel associates 601 Dresher Road, Suite 201 Horsham, PA 19044	sociates I, Suite 201 44	
The interplea	info nde	ot a	CONFIDENTIALITY NOTICE The information contained in this application is privileged and confidential information intended only for the use of the individual or entity named abo intended recipient, you are hereby requested that you should not further distribute or copy this information. In addition, if you have received this information. In addition, if you have received this information and interceived by you in error. Thank you for your compliance.	cation is privested that you	Cileged and confidential villeged and confidential ou should not further divident (800) 610-8300 and	ONFIDENT informatic stribute or destroy all	CONFIDENTIALITY NOTICE lal information intended only distribute or copy this inform distribute of copy this information all pages received the control of th	for the use of the indiversition, if you addition, if you in error. Thank	CONFIDENTIALITY NOTICE The information contained in this application is privileged and confidential information intended only for the use of the individual or entity named above. If you are not the intended recipient, you are hereby requested that you should not further distribute or copy this information. In addition, if you have received this information in error, please notify richard Gabriel associates immediately at (800) 610-8300 and destroy all pages received by you in error. Thank you for your compliance.

Prepared by richard Gabriel associates - Revised 2.1.2021