THE JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY

JIB Services, LLC – JIB Medical P.C.

Dear Participant:

Your employer's application to provide coverage for you and eligible dependents has been approved. Enclosed is a Summary Plan Description booklet detailing the provisions of the Plan(s); that you are eligible to participate in.

A. The Pension, Hospitalization and Benefit Plan of the Electrical Industry

ELIGIBLE DEPENDENTS ARE: 1) spouse and 2) children from birth up until their 26th birthday, regardless of marital or student status.

B. The Dental Benefit Plan of the Electrical Industry

ELIGIBLE DEPENDENTS ARE: 1) spouse and 2) unmarried children from birth up to their 19th birthday. However, full-time unmarried dependent students attending accredited institutions of higher learning shall be covered up to age 26 years. An original letter from the college registrar for the current semester shall be required as proof of current college attendance. The term "children" shall mean natural or legally adopted children.

The proper recording of your eligible dependents will facilitate payment of future claims. Please complete all of the information requested below and **return it to your employer with a copy of your marriage certificate, birth certificate(s) or adoption papers** for your children so that your eligible dependents will be properly recorded. Your employer will then forward these documents to the Plan to complete the enrollment process.

*****Opting out of the plan is not permissible*****

If you have any questions regarding eligibility or benefits, please call Laura Taylor O'Boyle at (718) 591-2000, Ext. 1316.

J-19HR

NEXT PAGE

JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY

158-11 HARRY VAN ARSDALE JR. AVENUE · FLUSHING, NY 11365
TEL: (718) 591-2000 · FAX: (718) 380-7741 · www.jibei.org

Please complete and return in the envelope provided:

PLEASE PRINT IN INK

EMPLOYEE DATA

_____ _____

Last Name **First** **Middle Initial** **Social Security #**

_____

Street Address **City** **State** **Zip Code**

Sex: ☐ **Male** ☐ **Female** **Phone#:**_____

Date of Birth:_____ **Hire Date:** _____

MARITAL STATUS

☐ **Married – Date of marriage:** _____ **Spouse's Birth Date:**_____
☐ **Widow(er)**
☐ **Divorced – If divorced, indicate name of divorced spouse** _____
Date of divorce: (MM/DD/YYYY)____/____/_____
☐ **Single**

*** (Attach copy of judgement of Divorce – including Stipulation of Settlement or QDRO if applicable)**

If you were divorced, is your ex-spouse entitled to any benefits pursuant to a Qualified Domestic Relations Order? ☐ **Yes** ☐ **No**

LIST BELOW NAME OF SPOUSE AND ELIGIBLE DEPENDENT(S) YOU WISH TO ENROLL.

PRINT IN ORDER OF AGE – Oldest First	Check (x) Relationship	Date of Birth	Social Security Number
	☐ Spouse ☐ Daughter ☐ Son		
	☐ Spouse ☐ Daughter ☐ Son		
	☐ Spouse ☐ Daughter ☐ Son		
	☐ Spouse ☐ Daughter ☐ Son		
	☐ Spouse ☐ Daughter ☐ Son		
	☐ Spouse ☐ Daughter ☐ Son		

SECTION 2: COORDINATION OF BENEFIT INFORMATION

If you or a dependent are a participant in another group health plan, please provide information about your coverage below and attach a copy of your health insurance card (front and back):

Name of other health plan: _____

Name of Policy Holder:_____**DOB:** _____

Type of Plan (check one): ☐ **Individual** ☐**Family**

Name of Person(s) Covered: _____

Policy Holder is (check one): ☐ **Actively Working** ☐ **Retired** ☐**Other (i.e. disabled)**

Effective date of coverage: _____

SECTION 3: PARTICIPANT'S SIGNATURE

Please print, sign your name, and date this form.

_____ _____

Print Name **Date**

_____

Sign Name

FOR USE BY MEMBERS RECORDS STAFF ONLY

ENROLLMENT DATE: _____

ELIGIBILITY EFFECTIVE DATE: _____

CARDS REQUEST WILL BE SUBMITTED ON: _____

CERTIFIED BY: _____

DATE: _____

Please direct questions regarding coverage and cards to: Members Records Extension 2491