



Health Fund

6281 Youngstown-Warren Rd., Suite 240
Niles, Ohio 44446
330-652-3475 FAX 330-652-3513
Toll Free 1-800-362-9354
www.ohiocarpenters.com

Re: Enrollment of Older (Between Ages 19 and 26) Dependent Children In Your Health Care Plan and Other Health Care Reform Changes

Dear Plan Participant:

As you are doubtless aware, Federal health care reform legislation, the Patient Protection and Affordable Care Act ("PPACA"), was signed into law last year. Some of its provisions first apply to the Ohio Carpenters Health and Welfare Plan on May 1, 2011, the first day of the first plan year starting after September 23, 2010, PPACA's effective date.

The extension/renewal of coverage for eligible dependent children between ages 19 and 26. Under PPACA, eligible dependent children under age 26, whose coverage ended or who were previously denied coverage or were not eligible for coverage because the availability of dependent coverage of children ended before attainment of age 26, are now eligible to enroll in the Plan during a special open enrollment period.

Coverage for eligible dependents will include your natural child, step-child, adopted child or a child placed with you for adoption until his or her 26th birthday. In addition, you may request the continuation or renewal of coverage for an eligible dependent child under the age of 26 even if the child is married and/or not dependent on you for support. However, your dependent child's spouse and/or children are not eligible dependents under the Plan and, therefore, are not eligible for coverage under the Plan.

Accordingly, you may now obtain coverage under the Plan for your eligible dependents between the ages of 19 and 26, even if that child's coverage was previously terminated due to attainment of age 19 (or 25, if a full-time student) or termination due to the child no longer qualifying as a full-time student. However, the dependent can only be enrolled in the Plan if the child IS NOT eligible for health coverage through his or her employer, if any, or through the employer of the child's spouse, if any.

Individuals must request enrollment for such children, including children currently covered as full-time students, within 30 days of the date of this notice. To enroll your eligible dependent child or children in the Plan, you must complete and submit the attached dependent enrollment form/affidavit to the Plan office within 30 days. You must complete one dependent enrollment form/affidavit for each such eligible dependent you are enrolling. You can make copies of the enclosed form for this purpose. **Failure to complete and submit the form within 30 days will result in your eligible dependent being denied enrollment in the Plan.**

If you have any questions about the enrollment of any eligible dependent between ages 19 and 26, please call the Fund office for assistance.

Very truly yours,

Joseph Ivan
Administrative Manager

Ohio Carpenters Health Plan

6281 Youngstown-Warren Road, Suite 240, Niles, OH 44446
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Older (Age 19-26) Dependent Health Care Enrollment Form / Affidavit MUST BE RETURNED WITHIN 30 DAYS FROM DATE OF THIS NOTICE

Employee Name: _____ Employee SSN or MMO ID No./or UBC No.: _____
Dependent Name: _____ Dependent Currently Enrolled? Yes or No
Dependent SSN: _____ Dependent Date of Birth: _____ / _____ / _____
Dependent Address: _____ Dependent Telephone No. _____

To be completed by the dependent:

1. Are you currently employed Yes or No
2. If yes, list the employer's name, address and telephone number
 - a. Employer Name: _____
 - b. Address: _____
 - c. Telephone Number: _____
3. Does your employer offer employee healthcare coverage? Yes or No
 - a. If yes, are you eligible for the health insurance coverage through your employer? Yes or No

I understand that dependent healthcare coverage is for eligible dependents under age 26. If I am between age 19 and 26, this coverage is only available if I am **NOT** eligible for health care coverage at my place of employment or through the employment of my spouse. I understand I am responsible for notifying the Plan office of changes to my employment or eligibility for employment-based health care coverage within 30 days of such change. I understand that failure to notify the Plan office of a change in my employment or eligibility for my employer's (or spouse's employer's) healthcare coverage as described in this affidavit may result in the denial of health care claims under the Plan or liability for reimbursement for benefits paid.

Signature of Dependent: _____ Date: _____

To be completed by the member:

I understand that dependent healthcare coverage is for eligible dependents under age 26. If my child is between age 19 and 26, coverage is only available if he or she is **NOT** eligible for health care coverage at their place of employment or through the employer of his or her spouse. I understand that my dependent is responsible for notifying the Plan office of changes to his or her employment or eligibility for their employer's healthcare coverage within 30 days of such change. I understand that failure to timely notify the Plan office of a change in his or her employment or eligibility for their employer's healthcare coverage as described in this affidavit may result in the denial of healthcare claims under the Plan or pursuit of reimbursement for benefits paid.

Signature of Member: _____ Date: _____

To be completed by the dependent's employer:

IF the answer to #1 above was "YES", this portion must be completed by the dependents employer.

_____ is an employee with _____
He / she is is not eligible for health care coverage with this organization.

Authorized Representative of Employer (please print) _____

Signature of Representative: _____ Date: _____

SEE REVERSE SIDE FOR ADDITIONAL DEPENDENT ENROLLMENT FORM/AFFIDAVIT

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Dependent Name: _____ Dependent Currently Enrolled? Yes or No
Dependent SSN: _____ Dependent Date of Birth: _____ / _____ / _____
Dependent Address: _____ Dependent Telephone No. _____

To be completed by the dependent:

1. Are you currently employed Yes or No
2. If yes, list the employer's name, address and telephone number
 - a. Employer Name: _____
 - b. Address: _____
 - c. Telephone Number: _____
3. Does your employer offer employee healthcare coverage? Yes or No
 - a. If yes, are you eligible for the health insurance coverage through your employer? Yes or No

I understand that dependent healthcare coverage is for eligible dependents under age 26. If I am between age 19 and 26, this coverage is only available if I am **NOT** eligible for health care coverage at my place of employment or through the employment of my spouse. I understand I am responsible for notifying the Plan office of changes to my employment or eligibility for employment-based health care coverage within 30 days of such change. I understand that failure to notify the Plan office of a change in my employment or eligibility for my employer's (or spouse's employer's) healthcare coverage as described in this affidavit may result in the denial of health care claims under the Plan or liability for reimbursement for benefits paid.

Signature of Dependent: _____ Date: _____

To be completed by the member:

I understand that dependent healthcare coverage is for eligible dependents under age 26. If my child is between age 19 and 26, coverage is only available if he or she is **NOT** eligible for health care coverage at their place of employment or through the employer of his or her spouse. I understand that my dependent is responsible for notifying the Plan office of changes to his or her employment or eligibility for their employer's healthcare coverage within 30 days of such change. I understand that failure to timely notify the Plan office of a change in his or her employment or eligibility for their employer's healthcare coverage as described in this affidavit may result in the denial of healthcare claims under the Plan or pursuit of reimbursement for benefits paid.

Signature of Member: _____ Date: _____

To be completed by the dependent's employer:

IF the answer to #1 above was "YES", this portion must be completed by the dependents employer.

_____ is an employee with _____
He / she is is not eligible for health care coverage with this organization.

Authorized Representative of Employer (please print) _____

Signature of Representative: _____ Date: _____