SUFFOLK COUNTY COURT EMPLOYEES ASSOCIATION WELFARE FUND
1363-24 Veterans Memorial Highway, Hauppauge, NY 11788 – PH: 631-231-3983
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2019 ANNUAL
ADULT DEPENDENT CERTIFICATION FOR UNION BENEFITS COVERAGE
4/1/2019 TO 3/31/2020

Should you wish a child between the ages of 19 to 26 to be covered under the Union Plan, this form must be completed and signed and returned to the Fund Office at the above address.

IMPORTANT NOTICE: This coverage is only available if the child is NOT eligible to enroll in another employer-sponsored health plan. This means that if a child was offered coverage by his or her own employer, or his or her spouse's employer, then the parent's plan would not be required to continue dependent coverage to age 26. WE MUST BE NOTIFIED IF COVERAGE IS AVAILABLE TO THE DEPENDENT FROM THEIR EMPLOYER.

SECTION 1: MEMBER INFORMATION

Last Name	First Name	Social Security (Last 4)
		___ ___ ___ ___
Address	**City, State**	**Zip**

SECTION 2: DEPENDENT:

Copies of birth certificates, adoption certificates, proof of legal guardianship, or your NYSHIP card with your dependent child's name must be attached IF THEY ARE NOT ALREADY ON FILE IN THE FUND OFFICE.

Last Name	First Name	M	F	Social Security Number
				_____ - ____ - _____
Address	**City, State**			**Zip**

Date of birth: _____ Marital Status:_____ Daytime Phone: ( ) _____

IN ADDITION, YOU MUST CERTIFY THAT YOUR CHILD IS NOT ELIGIBLE (DOES NOT HAVE THE AVAILABILITY TO OBTAIN) HEALTH COVERAGE THROUGH HIS/HER OWN EMPLOYER. PLEASE CHECK THE APPROPRIATE BOX BELOW:

- ☐ I hereby certify that the adult child shown above is NOT EMPLOYED as of the date of this notice.
- ☐ I hereby certify that the adult child shown above IS EMPLOYED, but is not eligible for health coverage through his/her employer.
- ☐ I hereby certify that the adult child is married but IS NOT eligible for health coverage through his/her spouse's employer.
- ☐ I hereby certify that the adult child is married and IS eligible for health coverage through his/her spouse's employer.

SECTION 3: DEPENDENT'S EMPLOYER NAME/ADDRESS/PHONE

If your dependent is employed, provide employer's name, address and phone number. If the dependent is married and the spouse is employed, provide information about the spouse's employer.

_____ _____

DEPENDENT'S EMPLOYER'S NAME **ADDRESS**

HUMAN RESOURCE OR BENEFITS DEPARTMENT TELEPHONE:_____

_____ _____

DEPENDENT'S SPOUSE'S EMPLOYER'S NAME **ADDRESS**

HUMAN RESOURCE OR BENEFITS DEPARTMENT TELEPHONE:_____

SECTION 4: NOTIFY FUND OFFICE OF OTHER COVERAGE ELIGIBILITY

You and/or your child shown above understand that you must notify the Fund office as soon as the child becomes eligible (has the availability to secure) employer-sponsored health coverage with his/her employer. If the Fund Office is not notified (letter, fax or e-mail) of other coverage/eligibility in a timely manner and claims are paid on the child's behalf, you and your child agree to promptly reimburse the Fund for any and all payments made on behalf of the ineligible child. If such reimbursements are not forthcoming, you understand that all future claim payments for you and/or any other enrolled dependents will be offset until full restitution is made.

In addition, you understand that legal action may be taken by the fund against you and/or your ineligible child to recover these ineligible claim payments and you and your dependent agree to be jointly and severally liable for all such misdirected payments, plus interest and attorney fees, as applicable.

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that if I conceal information, provide false information, or otherwise mislead the Fund, my child's eligibility for fund coverage may be terminated retroactively and I will be liable for any claims that were paid erroneously based on the false or misleading information.

_____ _____

MEMBER'S SIGNATURE **DATE**

_____ _____

DEPENDENT'S SIGNATURE **DATE**