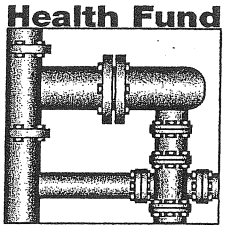

Connecticut Pipe Trades Health Fund
1155 Silas Deane Hwy
Wethersfield, CT 06109-4318
(860)571-9191 Fax (860)571-9221
www.connecticutpipetrades.com

Participant's Name_____
Address_____
_____

I.D. Number_____

CHILD CERTIFICATION FOR HEALTH COVERAGE

Should you wish a child age 19 or older and younger than age 26 to be covered under the Plan, this form must be completed, signed and returned to the Fund Office. Once verified, the child will be eligible as a dependent in the Plan **the first day of the following month.**

Child's Name: _____
Child's Date of Birth: _____
Child's Address: _____
_____
_____

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 child shown above is **not employed** as of the date of this notice.

☐ I hereby certify that the child shown above is employed **but is not eligible** for health coverage through his/her employer:

☐ I hereby certify that the child shown above is a **Full-Time Student** at an accredited college/school:

Child's Employer's Name: _____

Employer's Address: _____
_____
_____

Employer's Human Resource or
Employee Benefits Department Telephone:_____

(Continued on reverse)

Authorization To Receive HIPAA Protected Health Information: I authorize the Connecticut Pipe Trades Health Fund, or its duly appointed agent, to contact my employer at any time to verify my employment status and to ascertain whether I am eligible for health insurance coverage through that employer.

_____/_____

Dependent's Signature Date

Notify Fund Office of Other Coverage Eligibility: You and/or your child shown above understand that you must notify the Connecticut Pipe Trades Health Fund 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 email) 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 Health 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 individually liable for all such misdirected payments, plus interest and attorney fees, as applicable.

_____/_____

Participant's Signature Date

_____

Print Name

_____/_____

Dependent's Signature Date

_____

Print Name