WISCONSIN ELECTRICAL EMPLOYEES HEALTH AND WELFARE PLAN

DEPENDENT RE-ENROLLMENT FORM

SECTION ONE: Complete only if adding a dependent (Natural Child(ren), Adopted Child(ren) or Child Placed for Adoption) under age 26 back onto your policy.

Dependents Name	Social Security No.	Date of Birth	Relationship

Do any of the Dependents listed under section one have health insurance coverage through a Spouse and or Employment. Yes / No

*if Yes, please provide the Dependents Name, ID#, Group #, Health Insurance Carrier's Name, Address and Phone Number:

SECTION TWO: Complete only if adding a dependent (Step-Child(ren), Foster Child(ren) or Child(ren) whose Custody is Court Ordered/Guardianship) under age 26 back onto your policy.

Dependents Name	Social Security No.	Date of Birth	Relationship

Do the above Dependent(s) (section two only) (1) maintain a parent-child relationship with the Participant of the Plan, (2) does the Participant of the Plan provide for more than half of his/her financial support during the calendar year and (3) have the same residence as the Participant of the Plan for more than half the calendar year (except for temporary absences, such as attending school). Yes / No

*If you answered No then that dependent is NOT eligible for re-enrollment under your Plan.

Are the above Dependent(s) (in section two only) eligible for or enrolled with another health insurance carrier through a Spouse, Natural Parent(s) and/or Employment? Yes / No

*If you answered Yes then that dependent is NOT eligible for re-enrollment under your Plan.

PLEASE COMPLETE WAIVER ON BACK OF THIS RE-ENROLLMENT FORM:

WISCONSIN ELECTRICAL EMPLOYEES HEALTH AND WELFARE PLAN

RE-ENROLLMENT FORM WAIVER

By signing this Waiver/Release the undersigned (and, if applicable, his or her guardian(s)) acknowledges that he/she has read, understood and answered the questions in Section One and/or Section Two above accurately and completely. The undersigned also understands that it is their responsibility if at any time the information above changes they will contact the Fund Office immediately to update their records.

All claims, enrollment forms and any other information submitted or provided to the Fund, directly or indirectly, shall be accurate and complete. If the Board of Trustees finds, at any time, that false or inaccurate information has been submitted or provided to the Fund, directly or indirectly in support of a claim, the claim shall be denied. The Trustees shall have the right to offset an amount improperly paid and/or to terminate coverage for the eligible individual and eligible individual's covered family members.

- Please enclose complete copies of all applicable Birth Certificates, Divorce Decrees, Court Orders etc. that may apply to re-enroll your dependent(s) on the Plan.

Signature of Re-Enrolled Dependent	Date
Signature of Re-Enrolled Dependent	Date
Signature of Re-Enrolled Dependent	Date
Signature of Policyholder/Member/Guardian	Date
Printed Name of Policyholder/Member/Guardian	Anthem Insurance ID #