

# NATIONAL ORGANIZATION OF INDUSTRIAL TRADE UNIONS INSURANCE TRUST FUND

Re: Dependent Child Coverage for ages 18-26 under the NOITU Insurance Trust Fund (the "Plan")

Dear Participant:

If your Employer's Collective Bargaining Agreement with NOITU includes dependent health insurance coverage, your dependent child(ren) may be eligible for health coverage under the Plan, as a result of the new health care reform laws, effective January 1, 2011.

Eligible dependent children will maintain health coverage under the Plan up to the last day of the calendar year in which they become 18 years of age. In order for your dependent child(ren) (ages 18-26) to be covered by the Plan according to the terms of the Summary Plan Description ("SPD") previously provided to you, you **MUST** submit to the Plan all of the following:

- a copy of your child's birth certificate, if not previously provided
- a Dependent Child Application For Continuation of Health Coverage (enclosed)
- a fully signed and notarized Affidavit of Dependent Status every December (by December 31\*) for health coverage for the following calendar year (enclosed)

Thereafter, the Affidavit of Dependent Status must be provided every year during the open enrollment month of December (by December 31) for health coverage for the following calendar year.

Your dependent children aged 18-26 who previously lost eligibility because they attained the age of 19 or ceased to be full-time students are now eligible again, if they are younger than 26.

*Also enclosed is a Dependent Child Coverage Check List for your future reference.*

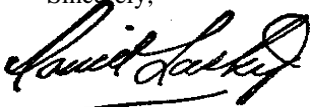
Please be advised that any misrepresentation in the information provided will permit the Plan to terminate your child's membership, rescind or retroactively terminate your membership, and seek any other legal remedies available to the Plan.

If you cannot provide the required documentation, please contact the Plan office immediately at (718) 291-3434 to discuss continuation coverage options that may be available to your dependent(s).

The NOITU Insurance Trust Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator of The NOITU Insurance Fund at 718-291-3434. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Sincerely,



Daniel Lasky  
Administrator

DL:nt  
Enclosures

**SE REQUIERE SU ATENCION INMEDIATA!** Estas paginas contiene un resumen en ingles de los beneficios de sus hijos en este Plan bajo NOITU Insurance Trust Fund. Si tiene dificultad entendiendo cualquier parte de estas paginas, llame a la oficina de 9:00 a.m. a 5:00 p.m., lunes a viernes, (718) 291-3434, ext. 600 para ayuda.



# **NOITU INSURANCE TRUST FUND**

## **Dependent Child (Ages 18-26) Coverage Check List**

Family membership under the NOITU Insurance Trust Fund may cover your dependent child(ren) after the last day of the calendar year in which they become 18 years of age through the last day of the calendar month in which they become 26 years of age. Your child may be eligible for dependent coverage if they meet all the following conditions:

1. your child is older than age 18 and younger than age 26, as above  
AND
2. Your child is **NOT** eligible for health insurance coverage under his/her Employer sponsored health insurance plan, or under his/her spouse's Employer sponsored health insurance plan.

### **Reasons Your Dependent Child's Coverage Will End**

- your dependent child reaches the last day of the calendar month in which your child attains age 26; or
- you do not provide an updated Dependent Child Application for Continuation of Health Coverage ; or
- You do not provide an updated, fully signed and notarized Affidavit of Dependent Status every December (by December 31) for health coverage for the following calendar year; or
- Your dependent child becomes **ELIGIBLE** for his/her Employer sponsored health insurance plan or his/her spouse's Employer sponsored health insurance plan.

### **Verifying and Keeping Your Child's Dependent Status**

Dependent child eligibility is reviewed during the month of December of each year. In order for your dependent child(ren) to continue to be covered by the Plan according to the terms of the Summary Plan Description ("SPD") previously provided to you, you **MUST** submit to the Plan every December (by December 31):

- a fully signed and notarized Affidavit of Dependent Status

It is **your responsibility** to notify the Fund Office immediately at 718-291-3434, regarding any changes in your child's employment status or eligibility for any Employer sponsored health insurance coverage.

### **When Your Child's Dependent Coverage Ends**

In order to continue coverage, your dependent child(ren) may be eligible for COBRA (Consolidated Omnibus Budget Reconciliation Act) continuation coverage. Please contact the Fund Office at 718-291-3434 to see if COBRA is an option.

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# AFFIDAVIT OF DEPENDENT STATUS NOITU INSURANCE TRUST FUND

**Instructions:**

- You must complete and return a separate Affidavit for each dependent child, ages 18-26.
- Affidavits should be mailed to the Fund Office at 148-06 Hillside Ave., Jamaica, NY 11435.
- Please call (718) 291-3434 if you have any questions.

STATE OF \_\_\_\_\_)

:SS:

COUNTY OF \_\_\_\_\_)

I, \_\_\_\_\_ (the "Participant"), being duly sworn, depose  
and declare as follows:

My child, \_\_\_\_\_,

(a) is beyond the last day of the calendar year in which he/she became 18  
years of age, and younger than the last day of the month in which he/she  
became 26 years of age

AND

(b) is not eligible for **any** Employer sponsored health insurance coverage

1. All statements are truthful to the best of my knowledge and I agree to  
inform the Plan Office immediately if at any time the statements made herein are no  
longer true.

2. I am obligated to inform the NOITU Insurance Trust Fund (the "Plan") of  
any change in my child, \_\_\_\_\_'s eligibility for health insurance  
coverage through his/her employment or through his/her spouse's employment.

*CONTINUED ON REVERSE SIDE*

3. To ensure accuracy, I acknowledge and agree that the Plan may investigate the status of my child's health insurance coverage through his/her employment or through his/her spouse's employment during the period in which my child is claiming dependent health insurance coverage through the Plan.

4. **I understand that any misrepresentation in the information I have provided will permit the Plan to terminate my child's coverage, rescind or retroactively terminate my coverage, and seek any other legal remedies available to the Plan.**

5. I shall indemnify and hold the Plan harmless for all costs incurred by the Plan and any taxes, tax related penalties or interest imposed in the event that any of the statements made herein are false.

6. I acknowledge that any coverage obtained based on incorrect information could lead to my being responsible for all costs incurred by the Plan.

\_\_\_\_\_  
Print Participant's Name

\_\_\_\_\_  
Dependent Child's Name

\_\_\_\_\_  
Participant's ID #

\_\_\_\_\_  
Dependent Child's SSN

\_\_\_\_\_  
Participant's Signature

Sworn to before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
NOTARY PUBLIC

**NOITU INSURANCE TRUST FUND**  
**DEPENDENT CHILD APPLICATION FOR CONTINUATION OF HEALTH COVERAGE**

Please provide the following information concerning your dependent child (ren), ages 18-26.  
 You must complete and return a separate Application for each dependent child, ages 18-26.

**Dependent Child Information (To be completed by Fund Participant & Child):**

<b>A. Member Information:</b>			
Last Name		First Name	Middle Initial (MI)
Mailing Address		Social Security Number	
City	State	Zip Code	
Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (Month/Day/Year)	Home Phone Number	Cell Phone Number
<b>B. Dependent Child You Wish to Enroll: Child's relationship to you:</b>			
<input type="checkbox"/> Natural <input type="checkbox"/> Adopted <input type="checkbox"/> Child placed with you for adoption <input type="checkbox"/> Stepchild <input type="checkbox"/> Foster Child <input type="checkbox"/> Legal Guardian			
Last Name		First Name	Middle Initial (MI)
Gender <input type="checkbox"/> F <input type="checkbox"/> M	Date of Birth (Month/Day/Year)	Social Security Number	
Is your dependent child:		Is your dependent child <b>Eligible</b> for any other employer-sponsored health, prescription, dental or vision coverage (even if not enrolled):	
<ul style="list-style-type: none"> <li>• Employed? <input type="checkbox"/> Yes    <input type="checkbox"/> No (If Yes, complete Section C)</li> <li>• Married? <input type="checkbox"/> Yes    <input type="checkbox"/> No If Yes, is child's spouse employed? <input type="checkbox"/> Yes    <input type="checkbox"/> No (If Yes, complete Section C)</li> </ul>		<ul style="list-style-type: none"> <li>• through his/her own employer? <input type="checkbox"/> Yes    <input type="checkbox"/> No (if Yes, complete Section D &amp; Section E)</li> <li>• through his/her spouse's employer? <input type="checkbox"/> Yes    <input type="checkbox"/> No (if Yes, complete Section D &amp; Section E)</li> </ul>	
<b>C. Employer Name/Address and Phone number:</b> If your child is employed, provide employer name, address and phone number. If the child is married and the spouse is employed, provide information about the spouse's employer.			
Adult Child's Employer Name:			
Employer Address and Phone Number:			
Adult Child's Spouse's Employer Name:			
Spouse's Employer Address and Phone number:			
<b>D. Eligibility for Other Health Care Coverage:</b> Complete the following section if your dependent child is currently <b>eligible</b> for health coverage through his/her own employment or his/her spouse's employment, even if not enrolled in coverage.			
Policyholder's Name:	Policyholder relationship to Child <input type="checkbox"/> Self <input type="checkbox"/> Child's spouse	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:		Address:	Phone #:

*CONTINUED ON REVERSE SIDE*

**E. YOUR CHILD'S EMPLOYER OR HIS/HER SPOUSE'S EMPLOYER MUST COMPLETE THIS SECTION BELOW.**

*The following information is to be completed by the dependent child's employer or his/her spouse's employer. Failure to have this form completed may result in a delay of coverage for your dependent.*

**NO** The above named dependent child is **NOT ELIGIBLE** for any Employer sponsored health insurance coverage.

**YES** The above named dependent child **IS ELIGIBLE** for Employer sponsored health insurance coverage.

**Please note:** You must answer this question "yes" as long as your employee (the above named dependent child or spouse of dependent child) is **eligible** for health coverage through your plan, regardless whether your employee is enrolled in your plan and regardless if there is a co-share for this plan.

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contact Person (Please Print)

\_\_\_\_\_  
Date

**Member Statement:** 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 Plan, my child's eligibility for Plan coverage will be terminated retroactively and I will be liable for any claims that were paid erroneously based on the false or misleading information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Dependent Child's Statement:** I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I authorize the Fund Office to contract my employer, my spouse's employer, as applicable, to verify the existence of other coverage that may be available to me through that employment. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my eligibility for Plan coverage will be terminated retroactively and I and my parent will be liable for any claims that were paid erroneously based on the false or misleading information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please Return This Form To:**  
**NOITU Insurance Trust Fund**  
**148-06 Hillside Avenue**  
**Jamaica, NY 11435-9977**  
**Phone #: (718) 291-3434**  
**Fax #: (718)526-2920**

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