

CANTON ELECTRICAL WELFARE FUND

Office Location
33 Fitch Boulevard
Austintown, Ohio 44515

Phone: (330) 270-0453
Toll Free: (800) 435-2388

NOTICE OF SUMMARY OF MATERIAL MODIFICATION TO PLAN

NOTICE OF DEPENDENT COVERAGE TO AGE 26

Due to changes required by the Affordable Health Care Act of 2010, the Board of Trustees of the Fund has recently made a change to the Plan/Summary Plan Description. The change is outlined below. Please keep this Summary of Material Modification with your Summary Plan Description.

You are now notified that, effective November 1, 2010, dependent children whose coverage ended, who were denied coverage, or who 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 Canton Electrical Welfare Fund. The coverage under the Fund will continue until the child reaches age 26.

Please note, however, that dependents up to age 26 are NOT eligible for coverage if and for so long as that individual is eligible for health insurance coverage offered by the individual's employer. Further, these individuals must immediately notify the Plan Administrator of eligibility for coverage by the individual's employer. Failure to do so and/or enrolling for coverage under this Fund when at the same time being eligible for the other employer health insurance coverage will subject the enrollee to criminal and civil penalties.

To obtain coverage under the Fund for the now-eligible dependent, Participants and/or individuals **MUST** enroll eligible dependent children not later than October 31, 2010. Use the enrollment form enclosed with this Notice and submit the form to the Plan Administrator not later than October 31, 2010.

The Plan Administrator is Compensation Programs of Ohio, Inc. 33 Fitch Blvd., Austintown, Ohio 44515. The Administrator's telephone number is 800-435-2388, and the fax number is 330-270-0912.

Should you need more information, please contact the Plan Administrator at the Administrator's address or telephone number.

BOARD OF TRUSTEES
CANTON ELECTRICAL WELFARE FUND

September 28, 2010

CANTON ELECTRICAL WELFARE FUND

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STATEMENT OF ADULT CHILD'S ELIGIBILITY UP TO AGE 26

PART I (TO BE COMPLETED BY PARTICIPANT)

	() -											
Participant's Name (Please Print)	Social Security Number	Telephone Number										
	() -											
Address	City	State Zip Code										
	() -											
Adult Child's Name	Social Security Number	Telephone Number										
<table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 10%; height: 20px;"></td> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;">/</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> <td style="width: 10%; text-align: center;">/</td> <td style="width: 10%; text-align: center;">1</td> <td style="width: 10%; text-align: center;">9</td> <td style="width: 10%;"></td> <td style="width: 10%;"></td> </tr> </table>			/			/	1	9			Adult Child's Relationship to Participant	
		/			/	1	9					
Adult Child's Birthdate (mm/dd/yyyy)												

Is Adult Child employed? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> Full-time <input type="checkbox"/> Part-time	
Name and Address of Employer:	
Is coverage available to Adult Child under his/her employer's group medical insurance plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, identify the other insurance carrier	Policy Number:
Name of Policyholder:	

I certify that:

- The listed Adult Child is eligible for coverage under the terms of the Canton Electrical Welfare Fund; and
- The information provided above is correct to the best of my knowledge and I authorize the release of any information requested, to the Canton Electrical Welfare Fund.

I understand that the Fund will, from time-to-time, require updated certification and that I must notify the Fund office immediately of any change in the status of my Adult Child (i.e. eligibility for health insurance under other medical insurance, including that of an employer).

Participant's Signature

Date

PART II (TO BE COMPLETED BY ADULT CHILD)

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Full name of Adult Child

Address of Adult Child

I certify that:

- I have reviewed the information contained on this form and that it is true and accurate.
- I will notify the above named participant in the event that I become eligible for coverage under any other employer sponsored health insurance (other than those policies sponsored by my parents' employer(s)).

I understand that the Fund will, from time-to-time, require updated certification and that I must notify the Fund office immediately of any change in my status (i.e. eligibility for health insurance under other medical insurance, including that of an employer).

Adult Child's Signature

Date