Youngstown Area Electrical Welfare Fund

33 Fitch Boulevard
Austintown, Ohio 44515
Phone: (330) 270-0453

NOTICE OF DEPENDENT COVERAGE TO AGE 26

This is a notice of a modification made to the Youngstown Area Electrical Welfare Fund and is being furnished to you as provided by law. This Notice should be kept with your Summary Plan Description booklet.

* * *

Effective January 1, 2011 individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in Youngstown Area Electrical Welfare Fund. This coverage will continue until the individual reaches age 26. Please note that these individuals 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.

To obtain coverage the participant and individual must request enrollment thirty (30) days from the date of notice. Use the enrollment form enclosed with this Notice and submit the form to the Plan Administrator not later than January 9, 2011. Enrollment will be effective retroactively to January 1, 2011.

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For more information contact the Plan Administrator at 33 Fitch Boulevard, Austintown, Ohio 44515 (phone: 1-800-435-2388). Please keep this information with your Summary Plan Description. As always, if you have any questions regarding these changes, please contact the Fund Office.

BOARD OF TRUSTEES

December 9, 2010

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Austintown, Ohio 44515
Phone: (330) 270-0453

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
		( ) -

Adult Child's Birthdate (mm/dd/yyyy)	Adult Child's Relationship to Participant
/ / 19	

Is Adult Child employed? ☐ Yes ☐ No	If Yes, ☐ Full-time ☐ Part-time	
Name and Address of Employer:		
Is coverage available to Adult Child under his/her employer's group medical insurance plan?		☐ Yes ☐ 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 Youngstown Area 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 Youngstown Area 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

(over)

PART II (TO BE COMPLETED BY ADULT CHILD)

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