IBEW LOCAL 236 HEALTH & BENEFIT FUND ENROLLMENT FORM

PARTICIPANT NAME (FIRST NAME + MI + LAST NAME)	SOCIAL SECURITY #	GENDER	DATE OF BIRTH (MM/DD/YY)	
MAILING ADDRESS (STREET, APT NO.)	CITY	STATE	ZIP CODE	TELEPHONE ( ) -
EMAIL ADDRESS:	MARITAL STATUS: ___SINGLE ___MARRIED	CLASSIFICATION: _____ACTIVE _____RETIREE		

WHICH PLAN TYPE(S) & COVERAGE AMOUNT(S) ARE YOU ENROLLING IN?

MEDICAL INSURANCE:	DENTAL INSURANCE: BLUESHIELD OF NENY
_____CDPHP - PPO $25; _____CDPHP - HDPPO; _____BSNENY - EPO $25 ______SINGLE ______2-PERSON ______FAMILY ______WAIVE/OPT OUT	_____SINGLE _____2-PERSON _____FAMILY _____WAIVED

INFORMATION ABOUT FAMILY PARTICIPANTS YOU WANT ENROLLED UNDER YOUR PLAN: (for additional dependents please attach another page, Proof of Marriage and Birth Certificates are required if adding spouse or dependent child(ren))

NAME (First Name + MI + Last Name)	ELECTING COVERAGE	WAIVING COVERAGE	SOCIAL SECURITY NUMBER	DATE OF BIRTH	GENDER
SPOUSE NAME:	___HEALTH ___DENTAL ___HRA	___HEALTH ___DENTAL ___HRA			
DEPENDENT NAME:	___HEALTH ___DENTAL ___HRA	___HEALTH ___DENTAL ___HRA			
DEPENDENT NAME:	___HEALTH ___DENTAL ___HRA	___HEALTH ___DENTAL ___HRA			
DEPENDENT NAME:	___HEALTH ___DENTAL ___HRA	___HEALTH ___DENTAL ___HRA			
DEPENDENT NAME:	___HEALTH ___DENTAL ___HRA	___HEALTH ___DENTAL ___HRA			
DEPENDENT NAME:	___HEALTH ___DENTAL ___HRA	___HEALTH ___DENTAL ___HRA			
DEPENDENT NAME:	___HEALTH ___DENTAL ___HRA	___HEALTH ___DENTAL ___HRA			

PARTICIPANT CERTIFICATION:

I hereby certify that the above information is correct. I further certify that I have read and agree to these Terms and Conditions: I, the above named participant, hereby authorize the elected benefit premiums noted above until such time as I should provide written notice to change or discontinue these deductions/reductions. I also authorize the Plan Administrator to make any future adjustments necessary should there be a change in the premium amounts for the coverage options I have selected. I agree to notify the Plan Administrator in writing of any changes to my personal information above that may affect the administration of my reimbursement benefits. I understand that neither my employer nor the Plan Administrator will be held liable for any delays or problems in the administration of my Plan or issue of my reimbursements, in the event that I fail to provide them with this information in an accurate and timely manner. I agree to be responsible for paying any fees associated with having the Plan Administrator reissue reimbursement checks to me, in the event that initial payments issued to me are lost, stolen, misplaced, or otherwise not received by me in a timely manner. If the Plan administrator determines that an expense I submitted for reimbursement, or that the JFA Flex Debit Card was used for a non-qualifying expense under the Plan, I shall immediately reimburse the Plan for the entire amount of the unqualified expense. By signing this enrollment form, I agree to have the amount of any over-reimbursed prescription claim deducted automatically from my HRA if my prescription coverage pays for a claim after my coverage has ended.

IBEW LOCAL 236 PARTICIPANT NAME	IBEW LOCAL 236 PARTICIPANT SIGNATURE	DATE SIGNED

For any questions you may have regarding completing this form or additional information that may be required contact the IBEW Local 236 Health & Benefit Fund (518) 782-5499 or Jaeger & Flynn Associates (JFA) (800) 388-8538. Please forward the completed form to the IBEW Local 236 Health & Benefit Fund at 3000 Troy Schenectady Rd., Schenectady, NY 12309-1614. Thank you.

TO BE COMPLETED BY IBEW LOCAL 236 HEALTH & BENEFIT FUND OFFICE:

Eligibility Date:_________________ Benefit Effective Date:_________________ Classification:_________ Insurance Code_________

Fund Office Signature______________________ Date Signed____________ HRA Account: ____Individual ____2-Person ____Family ____Waived

IBEW LOCAL 236 HEALTH & BENEFIT FUND

HEALTH PLAN AND HRA PLAN ENROLLMENT/WAIVER/OPT-OUT FORM AND HOLD HARMLESS AGREEMENT

Waiver Instructions: If you have other Affordable Care Act (ACA) Qualified Health Insurance coverage in effect through your spouse's or other family member's Employer-Sponsored Group Health Plan, you must complete and return Section One of this Form to the IBEW Local 236 Benefit Fund Office with either 1.) a copy of your insurance card that specifically identifies you as a covered dependent or 2.) a letter of coverage verification (which includes your name and policy/participant number) from your spouse's or other family member's insurance carrier.

Section One: Please check all applicable boxes below.

☐ Option 1: **Participant ONLY Health Plan and HRA.** I am enrolled in a health plan offered by IBEW Local 236 Health & Benefit Fund as of 1/1/2018. I elect to be enrolled in our Health Reimbursement Account (HRA) Plan. This HRA will reimburse me for my personal qualified medical, dental and/or vision Expenses. By choosing this option, I agree to have my IBEW Local 236 Health & Dental premiums deducted from my HRA. **Example: I have single insurance coverage through the IBEW Local 236 Health & Benefit Fund and I want to be eligible for reimbursement.**

☐ **Option 2: Participant and Family Health Plan and HRA**. My family and I are enrolled in a health plan offered by the IBEW Local 236 Health and Benefit Fund and I elect myself and my family to be enrolled in my Health Reimbursement Account (HRA) Plan. This HRA will reimburse myself and my covered dependents' for our personal qualified medical, dental, and/or vision expenses. By choosing this option, I agree to have my IBEW Local 236 Health & Dental premiums deducted from my HRA. **Example: I have 2-Person or family insurance coverage through the IBEW Local 236 Health & Benefit Fund and I want myself and my dependents to be eligible for reimbursement.**

☐ **Option 3: Participant Health Plan Opt-Out with HRA Enrollment.** I am enrolled in a health plan offered by another employer (i.e. your spouse's employer or other family member's employer or a retiree plan) and I elect to Opt-Out of the IBEW Local 236 Health Insurance but wish to be enrolled in the IBEW Health Reimbursement Account (HRA) Plan. This HRA will reimburse me (and any dependents who are also enrolled in a Qualified Health Plan) for qualified medical, dental and/or vision expenses and post-tax deductions for the employer sponsored health plan that I am enrolled in. **Example: I am opting out of insurance coverage through the IBEW Local 236 Health & Benefit Fund because I have other employer sponsored health insurance and I want myself and my dependents to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see the attestation form.**

☐ **Option 4: Participant ONLY enrolled in the IBEW Local 236 Health Plan with a Spouse and/or other dependents enrolled in the HRA:** I am enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund and my spouse and/or my dependents are not enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund, but are enrolled in a health insurance plan offered by another employer (i.e. your spouse's employer or other family member's employer or a retiree plan). I elect myself, my spouse, and my other dependents to be enrolled in my Health Reimbursement Account (HRA) Plan. This HRA will reimburse myself, my spouse and my other dependents for our personal qualified medical, dental and/or vision expenses. By choosing this option, I agree to have my IBEW Local 236 Health & Dental premiums deducted from my HRA. **Example: I have single coverage through the IBEW Local 236 Health & Benefit Fund, my spouse and children have health insurance through another employer sponsored plan and I want myself, my spouse and my dependents to be eligible for reimbursements. Proof of other health plan enrollment is required. Please see the attestation form.**

☐ **Option 5: Participant and/or Spouse enrolled in the IBEW Local 236 Health Plan or other sponsored health plan and dependent waiver:** I and my spouse and I am/are enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or another employer sponsored health plan and my dependents are NOT enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or a health insurance plan offered by another employer and I choose to waive my dependents from my Health Reimbursement Account (HRA) Plan. **Example: my children are enrolled in Child Health Plus, or Medicaid and not eligible for reimbursement under my plan. I want myself and/or my spouse to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see the attestation form.**

☐ **Option 6: Dependent Waiver:** My dependents are enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or a Health Insurance Plan offered by another employer and I choose to waive my dependents from my Health Reimbursement Account (HRA) Plan. This HRA will not reimburse me for my dependents' qualified medical, dental and/or vision expenses. **Example: My children are on my insurance plan or my spouse's plan but I DO NOT want them to be eligible for reimbursement. Proof of other health plan enrollment is required. Please see the attestation form.**

☐ **Option 7: Permanent HRA Waiver:** (This option is required to be offered however it is highly unlikely that you would choose this option, unless you are in the instance of where you wish to only use the exchanged and be eligible for the federal subsidies associated and available on the marketplace.) I am not enrolled in a health plan offered by the IBEW Local 236 Health & Benefit Fund or a health insurance plan offered by another employer (i.e. your spouse's employer or another family participant's employer plan) and I elect to waive myself and my dependents from the IBEW Local 236 Health Reimbursement Account (HRA) Plan permanently. **Proof of other health plan enrollment is required. Please see the attestation form.**

ATTESTATION OF ENROLLMENT IN EMPLOYER SPONSORED GROUP HEALTH PLAN AND HOLD HARMLESS AGREEMENT

I certify by listing my name (and covered dependents names) below that each name listed has qualified health insurance coverage through (check all that apply):

_____IBEW Local 236 Health & Benefit Fund or _____Another Employer or _____My spouse's (or other family member's employer or _____Other Government sponsored plan that meets the ACA definition of Minimum Essential Coverage (MEC*).

IBEW Local 236 Participant Name: _____ **Spouse's Name: _____**

Dependent: _____ **Dependent: _____**

Dependent: _____ **Dependent: _____**

Dependent: _____ **Dependent: _____**

Name of other insurance carrier (if not enrolled in IBEW Local 236 Health & Benefit Fund): _____

Policy # or Participant Identification #:_____ **Effective Date of Coverage:_____**

IBEW Local 236 Participant Social Security Number: _____ **IBEW Local 236 Participant Date of Birth: _____**

Marital Status: _____Single _____Married _____Widowed _____Divorced

I hereby elect not to have: _____ **my own _____ my spouse's and/or _____my child(ren)'s** (please check all boxes that apply) health insurance premiums withdrawn from my personal HRA account. I understand that by making this election, my own and/or my spouse's and/or my child(ren)'s health coverage under the IBEW Local 236 Health & Benefit Fund (the "Fund") will terminate on the effective date of other coverage (please provide dated proof of other coverage). I was given the opportunity to enroll myself and/or my spouse, and/or my child(ren) in the IBEW Local 236 Health & Benefit Fund's Group Health Benefits. By waiving my own and/or my spouse's and/or my child(ren)'s Health Insurance Benefit, I am not waiving any other Benefit offered by the IBEW Local 236 Health & Benefit Fund.

I understand that if I later wish to enroll myself and/or my spouse and/or my child(ren) for any coverage(s) waived, I can do so only during Open Enrollment or upon involuntary loss of coverage. I further understand that I must complete the proper enrollment forms at such time.

I have attached the following "Proof of Current Coverage" *:

_____ Employer/Insurer letter of coverage _____Insurance ID Card _____Other (Please describe):_____

Please note if this is your first time opting out you will also need to complete the IBEW Local 236 Health & Benefit Enrollment (change) form and supply proof with the exact date that your new coverage began.

In consideration of my being allowed to make this election, I hereby agree, for myself and/or my eligible dependents, to indemnify the Fund, the Trustees of the Fund and their participants, agents and representatives, and hold them harmless, against any damages, costs or expenses which they may suffer or incur, including reasonable attorney's fees, arising out of any actions, causes of action or claims for or relating to benefits to which I or any of my eligible dependents would have been entitled had I not made this election. This Agreement shall be binding upon my heirs, executors, administrators and assigns, and shall inure to the benefit of the Fund, its Trustees, Participants, Agents and Representatives, and their successors and assigns.

Participant's Signature_____ **Print Name**:_____ **Date:**_____

SPOUSAL SIGNATURE MUST BE NOTARIZED - IBEW Local 236 Participant's signature does not.

Spouse's Acknowledgement: (required if waiving coverage) **I certify that I am the spouse of:**_____
and I hereby consent to the foregoing Election and Hold Harmless Agreement.

Spousal Signature_____ **Print Name**_____ **Date**_____

NOTARY PLEASE COMPLETE: STATE OF:_____

COUNTY OF:_____

On the _____ day of _____ in the year 20_____

Notary Stamp or Seal:

before me, the undersigned personally appeared_____ **(name of person you are notarizing)**
who is personally known to me or proved to me on the basis of satisfactory evidence to be the individual(s) whose name are/is subscribed to the within instrument and acknowledged to me that he/she executed the same in his/her/their capacity(ies), and that by his/her signature on the instrument, the individual(s), or the person upon behalf of which the individual(s) acted, executed the instrument.

Notary Signature: