AUTOMATIC SPRINKLERS LOCAL 281, U.A. WELFARE FUND
DEPENDENT CHILD ENROLLMENT FORM (AGES 19 through 25)

To Be Completed for Enrollment for those Dependents who do not have other health care coverage available via their employment or their spouse's employment.

Participant's Name _____ SSN _____

Participant's Address _____

_____

Telephone # _____ Email Address _____

Dependent's Name _____ SSN _____

Dependent's Address (if different) _____

_____

Telephone # _____ Email Address _____

Is Dependent Employed? _____ If Yes, Name of Employer _____

Address of Dependent's Employer (If employed) _____

_____

Telephone Number of Dependent's Employer (if employed) _____

Is Dependent Married? _____ If So, Name of Dependent's Spouse _____

Is Dependent's Spouse Employed? _____ If So, Name of Employer _____

Address of Dependent's Spouse's Employer (If employed) _____

_____

Telephone Number of Dependent's Spouse's Employer (if employed) _____

I hereby attest that health care coverage is not available to this Dependent through either his/her direct employer or through his/her spouse's employer. The Fund Office has our permission to contact the employer(s) listed above, if applicable, for verification of health care coverage availability. I understand that if this information changes, it is our responsibility to notify the Fund Office immediately.

Participant's Signature _____ Date _____

Dependent's Signature _____ Date: _____