IUBAC Local 1 Connecticut Health Fund
230 Lexington Green Circle, Suite 400
Lexington, KY 40503
Toll Free: (888) 999-7741
Fax: (859) 226-1191

Welcome to the IUBAC Local 1 Connecticut Health Fund!

Dear IUBAC Member:

This enrollment package was sent to you because you are, or will be, eligible for health care coverage. In order to better understand the benefits that are available to you, it is important that you carefully read all of the information included. It is equally important that you fully and legibly complete and return all required documents as soon as possible. Any missing information or incomplete forms will delay the processing of your medical claims.

So you are aware, the Board of Trustees of the International Union of Bricklayers & Allied Craftworkers Local 1 Connecticut Health Fund (Fund) utilizes UMR as its third-party administrator. While the Fund covers IUBAC members who work in Connecticut, along with their eligible dependents, UMR is based out of Lexington, Kentucky.

Enclosed please find:

Vital Information Form:

Please fill out **all sections** of this form and return it to Local Union office located at 17 North Plains Industrial Road, Wallingford, CT 06492. List your spouse and any dependent children that you wish to have covered under the Fund. In the 'Beneficiary Information' portion, list any beneficiaries you wish to receive benefits that may be payable upon your death. The "Other Insurance Inquiry" section of this form must also be completed. This provides the Fund and UMR with information regarding other health insurance coverage and/or policies you or your dependents may have.

Dependent Coverage Letter:

This letter explains what documents you will need to add your spouse, dependent child(ren), stepchild(ren), and/or adopted child(ren). Please be advised if you do not return the necessary documentation your dependent(s) will **not** be added to your coverage. **You must provide a copy of your marriage certificate to add your spouse and birth certificates to add dependent children**. Additional documentation may be required for foster children, adopted children and stepchildren you wish to cover under the Fund.

IMPORTANT NOTICE

The Local Union office will coordinate with UMR such that they have all necessary information with respect to your Fund coverage, along with that of any of your eligible dependents.

If you have any questions please contact UMR by phone at 888-999-7741 or by mail at:

IUBAC Local 1 Connecticut Health Fund
c/o UMR
230 Lexington Green Circle, Suite 400
Lexington, KY 40503

Members who are seeking more information about rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, can contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) at 1-866-444-3272 or visit the EBSA website at *www.dol.gov/ebsa*.

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VITAL INFORMATION FORM

Member Name - Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: ____-____-____ Date of Birth: ____/____/____ Gender :(*circle one*) Male Female

Marital Status: *(circle one)* Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Current Status: *(circle one)* Active Retired Disabled COBRA

Telephone Number: (____) _____ Alternate Phone Number: (____) _____

Email Address: _____

Date of Member Initiation: _____

Medicare Claim Number: (including the letter(s) that follows the number)
(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member # _____ **Spouse #** _____ **Dependent # and Name** _____

DEPENDENTS: - Include Spouse (*Marriage/Birth Certificates are needed to add any new dependents to the plan)*

FULL NAME	RELATIONSHIP	DATE OF BIRTH	SOCIAL SECURITY NUMBER

BENEFICIARY INFORMATION:

NAME	RELATION	BIRTHDAY	S.S. #	ADDRESS/CITY/STATE/ZIP	%
(Primary)		__/__/__	___-___-___		
		__/__/__	___-___-___		
(Secondary)		__/__/__	___-___-___		
		__/__/__	___-___-___		

I agree to notify the Local Union office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

_____ _____
MEMBER SIGNATURE **Date**

OTHER INSURANCE INQUIRY

Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage that you participate in, or if there has been any change in other insurance coverage.

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____) _____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active? _____

Termination date if applicable: _____

Coverage is: (*circle one*) Single Family

Children are covered until age: _____

Type of coverage: (*circle all that apply*) Medical Dental Vision Prescription

List covered dependents: _____

_____

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Local Union office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

I Have No Other Insurance: _____
Initial Here/Sign Below

Member Signature:_____ **Date:** _____

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DEPENDENT COVERAGE

Please read the following information carefully! This letter explains the necessary requirements and documentation needed to add dependents to your health care coverage. Please refer only to the situation which applies to you, and forward the required information to the Local Union office.

SPOUSE - Coverage for a spouse can be provided for any eligible active or retired participant. You are required to complete a Vital Information Form for the purpose of verifying any other health insurance policy or coverage. To the extent you wish to add a spouse to your Fund coverage, a copy of your marriage certificate is required before coverage will be activated.

CHILDREN - The active participants' natural children, foster children and legally adopted children are eligible to be added to your Fund coverage. When adding eligible dependents to your coverage, a copy of each child's birth certificate is required before coverage will be activated.

STEPCHILDREN – Please be advised stepchildren are covered eligible dependents, but the Fund requires additional proof. Specifically, the Fund must receive a copy of the child's birth certificate which provides evidence that such child was a child of your spouse. The child may also be a foster child or legally adopted child of your spouse, so in those circumstances please be sure to provide the applicable legal documents verifying the foster child or adoptive status.

DEPENDENTS AGE 19 – 26 - In accordance with the Patient Protection and Affordable Care Act (PPACA also known as the "Affordable Care Act") health care plans such as our Fund that offer coverage for dependent children must provide coverage for adult children of covered employees until the age of 26. Thus, it is no longer a requirement that a dependent child over the age of 19 be a full-time student. Therefore, your children may be eligible for coverage until they attain age 26, regardless of their student or marital status, whether your home is their principal place of residence, or whether you support them. However, a copy of the child's birth certificate is always required.

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IMPORTANT -- By providing the Local Union office and UMR with appropriate legal documentation, as well as information regarding other health insurance policies or coverage your Spouse and/or children may have in addition to the IUBAC Local 1 Connecticut Health Fund, you are doing your part in controlling the ever escalating costs of your Health Plan benefits!