JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY

158-11 HARRY VAN ARSDALE JR. AVENUE • FLUSHING, N.Y. 11365
TEL: (718) 591-2000 • FAX: (718) 380-7741• www.jibei.org

Dear Participant:

Various benefits are administered through the Joint Industry Board which provide coverage for both the participant and the eligible dependents of the participant. You may participate in some or all of these plans.

A. Pension, Hospitalization and Benefit Plan of the Electrical Industry – Pension Trust Fund; Annuity Plan of the Electrical Industry

The Pension, Hospitalization and Benefit Plan of the Electrical Industry – Pension Trust Fund and the Annuity Plan of the Electrical Industry provide valuable benefits for your retirement. Please keep the enclosed Summary Plan Descriptions in a safe place for reference.

B. Pension, Hospitalization and Benefit Plan of the Electrical Industry; Deferred Salary Plan of the Electrical Industry; Health Reimbursement Account Plan of the Electrical Industry

Eligible dependents are: 1) spouse and 2) children from birth up to their 26th birthday, regardless of marital or student status.

C. Dental Benefit Fund of the Electrical Industry

Eligible dependents are: 1) spouse and 2) unmarried children from birth up to their 19th birthday. However, full-time, unmarried dependent students attending accredited institutions of higher learning shall be covered up to age 26 years. An original letter from the college registrar for the current semester shall be required as proof of current college attendance. The term "children" shall mean natural or legally adopted children.

D. Dental Benefit Plan of the Elevator Division

Eligible dependents are: 1) spouse and 2) unmarried children from birth up to their 19th birthday. However, full-time unmarried dependent students attending accredited institutions of higher learning shall be covered up to age 26 years. An original letter from the college registrar for the current semester shall be required as proof of current college attendance. The term "children" shall mean natural or legally adopted children.

The proper recording of your eligible dependents, and any other group health coverage available to them, will facilitate payment of future claims. Please complete the enclosed forms and return them in the enclosed envelope with a copy of the applicable marriage certificate, birth certificate(s) or adoption papers so that your eligible dependents may be properly recorded and enrolled.

To avoid a delay in processing, please include Social Security numbers for all dependents.

Sincerely,
Members' Records Department

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Enc.

Pension, Hospitalization and Benefit Plan of the Electrical Industry
158-11 Harry Van Arsdale Jr. Avenue, Flushing NY 11365
Members Records Dept. Phone: (718) 969-4030, Fax: (718) 591-2189

ENROLLMENT FORM

SECTION 1: PARTICIPANT INFORMATION:

Last Name First Name

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐ _____

PID (MagnaCare ID #) Date of Birth

Address

Phone Number Cell Phone Number Email Address

Enrolled in **another health plan?** Yes ☐ No ☐ **If yes, complete section 3.**

SECTION 2: DEPENDENT INFORMATION

1. Relation to Participant (Check One): ☐ Spouse DOB:_____ ☐ Child DOB:_____

Last Name First Name Social Security Number

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐ _____

Address

Enrolled in **another health plan?** Yes ☐ No ☐ **If yes, complete section 3.**

2. Relation to Participant (Check One): ☐ Child DOB:_____

Last Name First Name Social Security Number

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐ _____

Address

Enrolled in **another health plan?** Yes ☐ No ☐ **If yes, complete section 3.**

3. Relation to Participant (Check One): ☐ Child DOB:_____

_____

Last Name First Name Social Security Number

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐ _____

_____

Address

Enrolled in **another health plan?** Yes ☐ No ☐ **If yes, complete section 3.**

4. Relation to Participant (Check One): ☐ Child DOB:_____

_____

Last Name First Name Social Security Number

Assigned Sex at Birth: M ☐ F ☐ Current Sex: M ☐ F ☐ Other ☐ _____

_____

Address

Enrolled in **another health plan?** Yes ☐ No ☐ **If yes, complete section 3.**

SECTION 3: COORDINATION OF BENEFIT INFORMATION

If you or a dependent are enrolled in **another health plan**, please provide the details of that coverage below and attach a copy of the health insurance card (front and back).

Name of other health plan: _____

Name of Policy Holder: _____ DOB: _____

Type of Plan (check one): ☐ Individual ☐ Family

Name of Person(s) Covered: _____

Policy holder is (check one): ☐ Actively Working ☐ Retired ☐ Other (i.e. disabled)

Effective Date of Coverage: _____

SECTION 4: PARTICIPANT'S SIGNATURE

Please print, sign your name, and date this form.

_____ _____

Print Name Date

_____

Sign Name