Benefit Plan

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Under the Patient Protection and Affordable Care Act of 2010, the **Doctors Council Benefit Plan** (the Plan) can extend coverage to participant's eligible children[1] up to the end of the month in which the child attains age 26. Coverage is available whether the child is married or unmarried, regardless of student status, employment status, financial dependency on the participant, or any other factor other than the relationship between the child and the participant**.** *Please note that if the child is married, coverage, however, will not be extended to the child's spouse or children.*

Special Enrollment Instructions

Complete the attached form for each adult child you wish to enroll or extend coverage for. If you have more than one adult child, you will need to complete a separate form for each adult child. This Plan defines an adult child as an individual over age 18 and up to age 26 who is a natural child, legally adopted child, child placed for adoption, legal stepchild (defined as a child of your current spouse), foster child (within the meaning of Section 152(f) of the Internal Revenue Code), and child placed in your custody by a court order.

You must complete this form if you want to enroll:

- Children between the ages of 19 and 23 even if they are **currently** enrolled in the Plan;
- Children below age 26 who were not previously eligible to enroll in the Plan;
- Children below age 26 who were previously denied coverage under the Plan; and
- Children below age 26 whose coverage under the Plan already ended.

Please note: These children will not be eligible for coverage if they are eligible for any employment-based coverage other than the plan of a parent or step-parent.

You must complete this form in its entirety and then sign and date it before a Notary Public.

If your child is not currently enrolled in the Plan, you must provide a copy of the child's birth certificate. For adopted children or those placed for adoption with you, you must provide a copy of the adoption paperwork. For a stepchild, you must provide a copy of your and your spouse's marriage certificate, as well as the child's birth certificate. For foster child and children placed in your custody by a court order, you must provide a copy of your legal guardianship documents and a copy of the certified birth certificate. For temporary guardianship, you must provide a written document signed by both parents that must include the child's name, date of birth, date of guardianship placement, and an expiration date within 6 months of placement and a copy of the certified birth certificate. Additional documents may be required depending on the parental circumstances.

Additional Information:

The Plan will continue to cover disabled children under the current Plan's provisions. Please see your SPD for information on coverage for disabled children.

Email, Fax or Mail Form(s) to: **Doctors Council Benefit Plan**
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[1] Eligible children include children/grandchildren of the member who qualify as dependents under the Internal Revenue Code.

DOCTORS COUNCIL BENEFIT PLAN
SPECIAL ENROLLMENT FORM FOR ELIGIBLE ADULT CHILDREN UNDER AGE 26

A. Employee Information:			
Last Name	First Name		Middle Initial
Mailing Address			Social Security Number
City	State		Zip Code
Gender ☐ F ☐ M	Date of Birth: (Month/Day/Year)	Home Phone Number	Cell Phone Number

B. Adult Child Enrollment: Child's relationship to you:
☐ Natural Son/Daughter ☐ Adopted Child ☐ Child placed with you for adoption ☐ Stepchild
☐ Foster Child ☐ Child Placed in Your Custody by Court Order

Last Name	First Name	Middle Initial
Gender ☐ F ☐ M	Date of Birth: (Month/Day/Year)	Social Security Number

Is your adult child : (if *yes,* please complete Section C.) Currently enrolled in the Plan? ☐ Yes ☐ No Married? ☐ Yes ☐ No Employed? ☐ Yes ☐ No Is child's spouse employed? ☐ Yes ☐ No	Does your adult child have access* **to** other employer-sponsored coverage: (if *yes*, complete Section D) Through his/her own employer? ☐ Yes ☐ No Through his/her spouse's employer? ☐ Yes ☐ No

C. Employer Name/Address and Phone number: If your child is employed, provide employer name, address and phone number. If the child is married and the spouse is employed, provide information about the spouse's employer.

Adult Child's Employer Name:	
Employer Address and Phone number:	
Adult Child's Spouse's Employer Name	
Employer Address and Phone number:	

D. Eligibility for Other Health Care Coverage: Complete the following section if your adult child is currently *eligible for* health coverage either through his/her own employment or his/her spouse's employment.

Policyholder's Name:	Policyholder relationship to Child ☐ Self ☐ Child's spouse	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:	Address:		Phone #:

***access** – *denotes that the dependent has the ability to enroll in, or purchase health insurance through their employer regardless fo cost or benefits available.*

Employee Affidavit: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that if I conceal information, provide false information, or otherwise mislead the Fund, my child's eligibility for Fund coverage may be terminated retroactively and I may be liable for any claims that were paid erroneously based on the false or misleading information.

Signature_____ Date_____