Laborers' District Council
of the Metropolitan Area of
Philadelphia and Vicinity

Laborers' District Council Benefit Funds Enrollment Form

GCC/IBT 525-M

PLEASE DO NOT USE THIS FORM TO UPDATE YOUR CONTACT INFORMATION OR TO REQUEST A NAME CHANGE FOR YOU OR YOUR DEPENDENTS. CONTACT THE FUND OFFICE FOR A NAME CHANGE REQUEST FORM OR A CHANGE OF MEMBER CONTACT INFORMATION FORM. YOU MAY ALSO DOWNLOAD THESE FORMS AT www.myldcbenefits.com. GO TO FORMS AND DOWNLOADS.

INSTRUCTIONS:
- **ALL MEMBERS MUST COMPLETE SECTIONS 1, 4, AND 5.**
- **ALL MEMBERS ADDING OR DELETING DEPENDENTS MUST ALSO COMPLETE SECTION 2.**
- **ALL MEMBERS ADDING DEPENDENTS MUST ALSO COMPLETE SECTION 3 IF APPLICABLE.**

SECTION 1

PURPOSE OF FILING THIS FORM: ☐ I am a New Member ☐ I am Adding or Deleting Dependents

FIRST NAME	MI	LAST NAME	MEMBER'S SOCIAL SECURITY NUMBER	MEMBER'S DATE OF BIRTH MONTH DAY YEAR
STREET ADDRESS			MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED	
P.O. BOX RURAL ROUTE			MEMBER'S GENDER ☐ MALE ☐ FEMALE	
CITY	STATE	COUNTRY / ZIP CODE	SPOUSE'S EMPLOYER	SPOUSE'S SOCIAL SECURITY NUMBER
HOME PHONE NO.		CELLPHONE NO.	E-MAIL ADDRESS	ALTERNATIVE PHONE NO.

MEMBER OF:
☐ LABORERS' LOCAL 57 ☐ LABORERS' LOCAL 135 ☐ LABORERS' LOCAL 332 ☐ LABORERS' LOCAL 413 ☐ OTHER ____________

Are you covered by Medicare .... **Part A** ☐ Yes ☐ No **Part B** ☐ Yes ☐ No
Is your spouse covered by Medicare .... **Part A** ☐ Yes ☐ No **Part B** ☐ Yes ☐ No
Are any of your eligible dependents covered by Medicare .... **Part A** ☐ Yes ☐ No **Part B** ☐ Yes ☐ No
Is the member retired from military service .... ☐ Yes ☐ No **Part B** ☐ Yes ☐ No

IF NEW MEMBER, LIST ALL DEPENDENTS INCLUDING YOUR SPOUSE AND YOUR CHILDREN WHO HAVE NOT REACHED AGE 26.
IF EXISTING MEMBER, ONLY LIST DEPENDENTS YOU WISH TO ADD OR DELETE.

FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER, IF DEPENDENT'S EMPLOYER OFFERS HEALTH INSURANCE, COMPLETE SECTION 3	
FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER, IF DEPENDENT'S EMPLOYER OFFERS HEALTH INSURANCE, COMPLETE SECTION 3	
FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER, IF DEPENDENT'S EMPLOYER OFFERS HEALTH INSURANCE, COMPLETE SECTION 3	
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DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER, IF DEPENDENT'S EMPLOYER OFFERS HEALTH INSURANCE, COMPLETE SECTION 3	
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FIRST NAME	MI	LAST NAME	☐ Spouse ☐ Child ☐ Stepchild ☐ Adopted	DATE OF BIRTH MONTH DAY YEAR	DEPENDENT'S SOCIAL SECURITY NUMBER
DEPENDENT'S GENDER ☐ MALE ☐ FEMALE		☐ ADD ☐ DROP		NAME OF SCHOOL/COLLEGE OR EMPLOYER, IF DEPENDENT'S EMPLOYER OFFERS HEALTH INSURANCE, COMPLETE SECTION 3	

If you wish to drop a dependent, please contact the Fund office before returning this card.

Any fund accepting this card for census enrollment requires that you submit one or all of the following documents to substantiate the dependent status of any individual listed on this card as your dependent:

- Marriage certificate or common law marriage affidavit if common law marriage was established prior to January 1, 2005; please contact office for common law affidavit.
- Birth certificate for each member, spouse and dependent child (must list names of each parent); or domestic court order; or support order.
- Hospital birth record for each newborn child (if no birth certificate is available), birth records need to list names of each parent.
- For step-child(ren), please show: (i) marriage certificate listing the biological parent and (ii) birth certificate listing biological parent;
- For adopted child(ren), please show adoption documentation or birth certificate with member's name.
- For foster child(ren), please provide proof that foster child is a dependent of the participant for support and maintenance and that no other medical insurance is reasonably available to cover such foster child(ren).
- Copy of social security card for member and each dependent listed on this form.

Dependent eligibility will be determined by the Fund. You may be required to provide additional proof to confirm the eligibility status of one or all of the above dependents.

*** MUST COMPLETE AND SIGN REVERSE SIDE ***

SECTION 3
OTHER COVERAGE

Coordination of Benefits applies when you or any dependent receive benefits under more than one health insurance program. Coordinating benefits helps to contain the cost of health care and can save you some out-of-pocket expenses when balances remain after one carrier has made its claim payment. If you, your spouse or other dependent provide incomplete, false or otherwise misleading information on this form, then the Plan Administrator will provide notice to you that your spouse's or other dependent's coverage under this Plan is suspended until complete or correct information is provided.

OTHER COVERAGE A (SPOUSE REQUIRED TO COMPLETE IF HE/SHE HAS ACCESS TO EMPLOYER PROVIDED HEALTH COVERAGE)

SECTION 3

NAME OF DEPENDENT WITH OTHER COVERAGE FIRST NAME MI LAST NAME		POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH MONTH DAY YEAR	GENDER ☐ MALE ☐ FEMALE
NAME OF OTHER EMPLOYER		ADDRESS OF OTHER EMPLOYER		
NAME OF OTHER INSURANCE CARRIER		ADDRESS OF OTHER INSURANCE CARRIER		
TYPE OF COVERAGE ☐ Individual ☐ Family	BENEFITS PROVIDED ☐ Hospital ☐ Dental ☐ Med/Surgical ☐ Optical ☐ Prescription	PHONE NO. OF OTHER INSURANCE CARRIER		
EFFECTIVE DATE MONTH DAY YEAR		TERMINATION DATE MONTH DAY YEAR	PERCENTAGE SPOUSE PAYS TOWARD EMPLOYER COVERAGE	

OTHER COVERAGE B (COMPLETE FOR NON-SPOUSE/DEPENDENT)

SECTION 3

NAME OF DEPENDENT WITH OTHER COVERAGE FIRST NAME MI LAST NAME		POLICY OR OTHER IDENTIFICATION NO.	DATE OF BIRTH MONTH DAY YEAR	GENDER ☐ MALE ☐ FEMALE
NAME OF OTHER EMPLOYER		ADDRESS OF OTHER EMPLOYER		
NAME OF OTHER INSURANCE CARRIER		ADDRESS OF OTHER INSURANCE CARRIER		
TYPE OF COVERAGE ☐ Individual ☐ Family	BENEFITS PROVIDED ☐ Hospital ☐ Dental ☐ Med/Surgical ☐ Optical ☐ Prescription	PHONE NO. OF OTHER INSURANCE CARRIER		
EFFECTIVE DATE MONTH DAY YEAR		TERMINATION DATE MONTH DAY YEAR		

IF YOU HAVE ADDITIONAL DEPENDENTS WITH OTHER COVERAGE, PLEASE PROVIDE INFORMATION ON ADDITIONAL SHEETS.

SECTION 4

CONSENT TO ELECTRONIC DISCLOSURE

The undersigned participant or beneficiary hereby consents to receive plan documents and notices I am entitled to receive under ERISA, including summary plan descriptions, summaries of material modification, notices of significant reduction in benefit accruals, summaries of benefits and coverage, summary annual reports, notices of endangered or critical status, notices of creditable coverage, and womens health and cancer rights act notices, electronically via e-mail at the address listed below. By signing this consent, I acknowledge that I have the capability of accessing PDF documents via computer, smartphone, or tablet, and that the e-mail address I have listed below is my true and accurate e-mail address. I will notifiy the Fund Office in writing of any change to my e-mail address. I understand that I may withdraw this consent at any time by notifying the Fund Office in writing by mail or e-mail at the following address: [665 North Broad Street, 2nd Floor, Philadelphia, PA 19123 ATTN: Electronic Disclosure: enrollment@myldcbenefits.com]. I am aware that any such withdrawal shall become effective only after it is received by the Fund Office. I understand that I may obtain a paper copy of any documents furnished electronically pursuant to this consent free of charge upon request.

Signature _____ Email _____ Date _____

SECTION 5

CERTIFICATION

The undersigned Participant hereby certifies that any and all information supplied on this Benefits Enrollment Form is true and correct and understands that coverage may be rescinded for misrepresented information or fraud. I certify that any adult child listed above has not reached the age of 26. Further, in the event of fraud or intentional misrepresentation, the Fund will require you to repay the Plan for the full amount of any benefits improperly received. I further consent and permit the information contained herein to be used by any and all Laborers' District Council Benefit Funds.

Member's Signature _____ Date _____

Please complete and return this form:

- **Mail:** 665 North Broad Street, 2nd Floor, Philadelphia, PA 19123
- **Fax:** 215-763-4380
- **Email:** enrollment@myldcbenefits.com

Please contact Member Services at (877) LABOR-77, (215) 236-6700 or (215) 765-4633 for any questions relating to this form. Go to myldcbenefits.com or e-mail us at enrollment@myldcbenefits.com.