# IUOE Local 4 Health and Welfare Fund
# Young Adult Eligibility Certification Form

The Affordable Care Act allows young adults to enroll in their parents' health care plan until age 26 **(as long as the young adult does not have access to their own employment based health plan)** even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. This applies to both married and unmarried children, although the dependent's spouse and children are not eligible to enroll.

By completing and signing below, you certify that the dependents listed below are not eligible to enroll in their own employment based health plan. If the young adult does become eligible to join their own employment based health plan, it is your responsibility to notify the Fund Office in writing of the effective date of the new insurance.

**PARTICIPANT NAME (Please Print)**

Last | First | MI | Social Security Number

**DEPENDENT NAME (Please Print)**

Last | First | MI | Social Security Number

Dependent Date of Birth | Relationship to Participant

Street Address (if different from Participant) | Apt. | City, State, Zip

Other Insurance (i.e., if enrolling in Plans of both parents)

Requested Date of Coverage

**DEPENDENT NAME (Please Print)**

Last | First | MI | Social Security Number

Dependent Date of Birth | Relationship to Participant

Street Address (if different from Participant) | Apt. | City, State, Zip

Other Insurance (i.e., if enrolling in Plans of both parents)

Requested Date of Coverage

**DEPENDENT NAME (Please Print)**

Last | First | MI | Social Security Number

Dependent Date of Birth | Relationship to Participant

Street Address (if different from Participant) | Apt. | City, State, Zip

Other Insurance (i.e., if enrolling in Plans of both parents)

Requested Date of Coverage

**If you have additional young adult dependents (between the age of 19 and 26) to add you may photocopy this form or download a copy from the Fund's website: www.local4funds.org**

**CERTIFICATION**

**Under penalties of perjury, I declare that the information I have furnished above, to my knowledge and belief, is true and complete and that my dependent is not eligible for their own employment based health insurance:**

Participant Signature | Date | Telephone

Email Address

**Note: A birth certificate copy is required for dependents not previously enrolled through IUOE Local 4 Health and Welfare Fund, or any other documentation that the Fund Office may deem necessary for dependency. Contact the Fund Office at 1-888-486-3524 if you have any questions.**

**Please return form and any required documentation to:**
**IUOE Local 4 Health and Welfare Fund**
**P.O. Box 660**
**Medway, MA 02053**