WEST VIRGINIA LABORERS' TRUST FUND

ONE UNION SQUARE
SUITE 200
CHARLESTON, WEST VIRGINIA 25302

PHONE (304) 342-5142
FAX (304) 342-2610
STEVEN L. SMITH, Administrative Manager
JUDITH LILLY, Executive Secretary

CHILD CERTIFICATION FOR HEALTH COVERAGE

Should you desire for your child age 19 or older and younger than age 26 to be covered under the Plan, this form must be completed and signed and returned to the West Virginia Laborers Health & Welfare Plan.

Childs Name:_____
Childs Date of Birth:_____
Childs Address:_____
_____
_____

In addition, you must certify that you child is not eligible (DOES NOT HAVE THE AVAILABILITY TO OBTAIN) Health Coverage through his/her own employer. Please check the appropriate box below:

{ } **I hereby certify that the child shown above is *not employed* as of the date of this certification.**

{ } **I hereby certify that the child shown above is employed *but is not eligible* for health coverage through his/her employment.**

Name of Childs Employer:_____
Employers Address: _____
_____

Employer Human Resource or
Employee Benefits Department Telephone:_____

Authorization to Receive HIPAA Protected Health Information: I authorize the West Virginia Laborers Health & Welfare Plan, or its duly appointed agent, to contact my employer at any time to verify my employment status and to ascertain whether I am eligible for health insurance coverage through that employer.

_____/_____
Dependent's Signature **Dated**

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Notify fund Office of Other Coverage Eligibility: You and/or your child shown above understand that you must notify the West Virginia Laborers Health & Welfare Plan as soon as the child becomes eligible (has the availability to secure) health coverage with his/her employer. If the fund Office is not notified of other coverage/eligibility in a timely manner and claims are paid on the child's behalf, you and your child agree to promptly reimburse the Health Fund for any and all payments made on behalf of the ineligible child. If such reimbursements are not forthcoming, you understand that all future claim payments for the member's claims, and/or any other enrolled dependent's claims, will be offset until full restitution is made. In addition, you understand that legal action may be taken by the Fund against you and/or your ineligible child to recover these ineligible claim payments, and you and your dependent agree to be jointly and severally liable for all such misdirected payments, plus interest and attorney fees as applicable.

I acknowledge and agree to the foregoing:

_____/_____

Member's Signature Dated

_____

Member's Name (Printed)

I acknowledge and agree to the foregoing:

_____/_____

Dependent's Signature Dated