EQUITY-LEAGUE BENEFIT FUNDS
PENSION, HEALTH & 401(K)

165 West 46th Street, Suite 812
New York, NY 10036-2582
Phone: (212) 869-9380 or (800) 344-5220
Fax: (212) 869-3323
Website: www.equityleague.org

Participant Name: _____ **AEA Union Identification Number:** _____

Dependent Coverage Form
PLEASE PRINT OR TYPE

You can elect to enroll your eligible dependents for medical and vision coverage. If you elect dependent coverage, you are required to pay the applicable premium for dependent coverage. Also note that you will lose dependent coverage if you fail to make a payment when due.

For Health Fund purposes, your eligible dependents include:

- your spouse to whom you are legally married under the laws of the state in which you reside, to the extent not otherwise prohibited by law
- your unmarried or married adult dependent **children** through the end of the month in which they reach 26. Dependent coverage does not apply to the adult child's spouse or children.
- your unmarried **disabled children** of any age - if the child became disabled while covered under our Health Plan before age 19 as your dependent. (However, if your dependent child's disability occurs **after** reaching age 19, he or she can still qualify under the Fund for health coverage until the last month of his or her 26th birthday).
- a **domestic partner**. (Please contact Fund Office for additional information.)

When you enroll a dependent, you should be prepared to provide proof of dependent status – for example, a marriage certificate, birth certificate, proof of residence and/or proof of financial dependency.

Please complete the information requested below.

NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH	SEX		RELATION TO YOU		
			Male	Female	SPOUSE	CHILD	DOMESTIC PARTNER
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐
			☐	☐	☐	☐	☐

Please return this completed form, along with your premium payment to:

Equity League Health Trust Fund
165 West 46th Suite 812
New York, NY 10036-2582