# DECLARATION OF ADULT DEPENDENT STATUS

The following open enrollment period is being offered to you between November 1 and November 30, 2010.

Effective January 1, 2011, the AFL Hotel & Restaurant Workers Health & Welfare Trust Fund, will cover a Participant's adult child dependent who meets the requirements set forth below. In order for such coverage to be effective as of January 1, 2011, the Trust Office must receive your declaration and the required documentation listed below no later than November 30, 2010. If your documents are received after November 30, 2010, coverage will be effective in accordance with Plan rules.

This declaration is required to enroll adult child dependents who are beyond the age of 18, until they reach the age of 26. **You must promptly submit this form to the AFL Hotel & Restaurant Workers Health & Welfare Trust Fund Office c/o BRMS, 560 N. Nimitz Hwy., #209, Honolulu, Hawaii 96817 in order to enroll your adult dependents.**

I, _____(participant name), declare and state under penalty of perjury that all of the following facts are true and correct as of the date of this declaration. I will also immediately notify the AFL Hotel & Restaurant Workers Health & Welfare Trust Fund if my adult dependent becomes eligible for health insurance coverage with his/her employer, so that my plan can remove my adult dependent from coverage.

Each adult child dependent named below meets all of the following eligibility requirements for coverage:

a. Between the ages of 19 and 26 – even if they were previously removed from your coverage;
b. Is the subscriber's natural child, step-child, legally adopted child, children placed in the home in anticipation of adoption or child of a qualified domestic partner if the domestic partner is currently enrolled;
c. Is not eligible for health insurance coverage under his/her employer or is not eligible for health insurance under his/her spouse's employer medical plan.

**Please submit a copy of the birth certificate, or certification of adoption or placement for adoption, of each adult child dependent with this Declaration.**

| | |
|---|---|
| Participant Name (Print): | _____ |
| Participant Signature: | _____ |
| Participant's Social Security Number: | _____ Date: _____ |

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List first and last name, date of birth, and Social Security Number of each dependent that meets the requirements above:

| Name | D.O.B. | Social Security Number |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

Trust Fund Representative Signature: _____

Name (Print): _____

Title: _____ Date: _____