DECLARATION OF ADULT DEPENDENT STATUS

The following open enrollment period is being offered to you between November 15, 2010 and December 20, 2010.

Effective January 1, 2011, the Hawaii Teamsters 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 December 20, 2010. Thereafter, enrollment for Extension of Dependent Coverage to Age 26 is limited to each Annual Open Enrollment Period.

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 Hawaii Teamsters Health & Welfare Trust Fund Office c/o BRMS, 560 N. Nimitz Hwy., #209, Honolulu, Hawaii 96817 or the Satellite Office at 1817 Hart Street, Honolulu, Hawaii 96819 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 Hawaii Teamsters 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 biological child, step-child, legally adopted child, or child for whom the employee has legal guardianship, legal custody, or an interlocutory order of adoption; and
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, placement for adoption, interlocutory order of adoption or legal guardianship/custody 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: _____