**Greater Metropolitan Hotel Employers-Employees Health and Welfare Fund**
Administered by Wilson-McShane Corporation
3001 Metro Drive – Suite 500
Bloomington, MN 55425

Phone: (952) 854-0795
Fax: (952) 854-1632
Toll Free: (800) 535-6373

# DEPENDENT CHILD(REN) COVERAGE ENROLLMENT FORM

Eligible employees may add their Dependent Child(ren) to be covered under the Greater Metropolitan Hotel Employers-Employees Health & Welfare Plan. Dependent Child: Means the employee's dependent children from birth to the end of the month in which they attain age 26. A Dependent Child includes a son, daughter, stepson, stepdaughter or an eligible foster child.

The cost of coverage of $ 613.05 (eff. 2/1/2024-01/31/2025) per Dependent Child(ren) per month will be the responsibility of the eligible employee, and due by the first of the month for that month's coverage.

In order to add your Dependent Child(ren) to coverage under the Plan, you must complete the following Enrollment Form, provide the required dependent documentation, and return this information together with the monthly premium(s) to the Fund Office within 30 days from the date of this notice.

Eligible Employees may enroll their Dependent Child(ren) when first eligible for coverage under the Plan. Should you have a new child by either birth or adoption, you must notify the Plan within 30 days of the birth or adoption of the Dependent Child if you wish to cover the child under this Plan and complete the enrollment process within 60 days of the birth or adoption. Thereafter, should the Eligible Employee not enroll their Dependent Child(ren) when the Eligible Employee is first eligible for coverage under the Plan, the Eligible Employee may only thereafter enroll their Dependent Child(ren) should they be legally entitled to do so under the HIPAA Special Enrollment requirements.

PLEASE NOTE – The Dependent Care Reimbursement Benefit ONLY applies to coverage not purchased under this Plan.

Please complete the Enrollment Form and return it with the required information and monthly premium(s) to the Fund Office.

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# Greater Metropolitan Hotel Employers-Employees Health & Welfare Plan
# ENROLLMENT FORM

Required information - A copy of the birth certificate or adoption papers, court order, and for stepchildren also a marriage certificate.

Employee's Full Name: _____
Last First Middle

Employee's Social Security Number: _____ Phone Number: _____

Employee's Address: _____
Street City State Zip Code

Dependent Child's Name: _____
Last First Middle

Child's Social Security Number: _____ Male or Female (Please Circle One)

Child's Date of Birth: _____
Month / Day / Year

Employee's Signature: _____ Date: _____