MASTERS, MATES AND PILOTS PLANS
Administrator
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ENROLLMENT FORM FOR ELIGIBLE ADULT CHILDREN AGE 19-26

A. Employee Information:

Last Name	First Name	Middle Initial (MI)
Mailing Address		Social Security Number
City	State	Zip Code
Gender ☐F ☐M / Date of Birth: (Month/Day/Year)	Home Phone Number	Cell Phone Number

B. Adult Child Enrollment: Child's relationship to you:
☐ Natural ☐ Adopted Child ☐ Child placed with you for adoption ☐ Stepchild ☐ Legal Guardianship

Last Name	First Name	Middle Initial (MI)
Gender ☐F ☐M / Date of Birth: (Month/Day/Year)	Social Security Number	

Is your adult child :
- Currently enrolled in the Plan? ☐Yes ☐ No
- Married? ☐ Yes ☐ No
- Employed? ☐Yes ☐ No
- Is child's spouse employed? ☐Yes ☐ No
  (if yes, complete Section C)

Is your adult child ***Eligible for*** other employer-sponsored coverage (even if not enrolled):
- through his/her own employer? ☐ Yes ☐ N
- through his/her spouse's employer? ☐ Yes ☐ N
  (if yes, complete Section D)

C. Employer Name/Address and Phone number: If your child is employed, provide employer name, address and phone number. If the child is married and the spouse is employed, provide information about the spouse's employer.

Adult Child's Employer Name:	
Employer Address and Phone number:	
Adult Child's Spouse's Employer Name	
Employer Address and Phone number:	

D. Eligibility for Other Health Care Coverage: Complete the following section if your adult child is currently ***eligible for*** health coverage either through his/her own employment or his/her spouse's employment, even if not enrolled in coverage.

Policyholder's Name:	Policyholder relationship to Child ☐Self ☐Child's spouse	Policyholder Date of Birth:	Group and Policy #:
Insurance Company/Claims Administrator Name:	Address:		Phone #:

Employee Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my child's eligibility for Plan coverage will be terminated retroactively and I will be liable for any claims that were paid erroneously based on the false or misleading information. Signature_____ Date_____

Adult Child's Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I authorize the Plan Office to contact my employer to verify the existence of other coverage that may be available to me through that employment. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, my eligibility for Plan coverage will be terminated retroactively and I and my parent will be liable for any claims that were paid erroneously based on the false or misleading information. Signature_____ Date_____

Adult Child's Spouse's Statement: I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge. I authorize the Plan Office to contact my employer to verify the existence of other coverage that may be available to my spouse through my employment. I understand that if I conceal information, provide false information, or otherwise mislead the Plan, I, my spouse and his/her parent will be liable for any claims that were paid erroneously based on the false or misleading information.

Signature_____ Date_____