

EQUITY – LEAGUE



165 West 46th Street
New York, NY 10036-2582

Pension, Health, and 401(k) Trust Funds

Executive Director Arthur Drechsler

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
- 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, certification of student status, proof of residence and/or proof of financial dependency.

Please complete the information requested below.

| NAME | S.S # | DATE OF BIRTH | RELATION TO YOU | | |
|------|-------|---------------|--------------------------|--------------------------|--------------------------|
| | | | SPOUSE | CHILD | DOMESTIC PARTNER |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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

**Equity League Health Trust Fund
165 West 46th Street (14th FLOOR)
New York, NY 10036-2582**