MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

14 NEW ENGLAND EXECUTIVE PARK • SUITE 200
BURLINGTON, MASSACHUSETTS 01803-5201
TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX 781-238-0703

Haga Clic Aquí para Versión en Español

ENROLLMENT FORM

Please use this form to enroll any dependent child between the ages of 19 to 26 years. If your dependent child between the ages of 19 to 26 is eligible for ANY employer sponsored health insurance plan, then he/she is not eligible for health insurance coverage by the Massachusetts Laborers' Health and Welfare Fund.

In order to enroll your 19 to 26 year old dependent, you must fully complete the following information, and your son or daughter must fully complete the enclosed Authorization to Obtain Earnings Data from the Social Security Administration (Form SSA-581):

I. Member Name: _____ Social Security #:_____

Address: _____
(Street) (City/Town/State) (Zip Code)

Dependent Name: _____ Social Security #:_____

Address: _____
(If Different From Above) (City/Town/State) (Zip Code)

Dependent Name: _____ Social Security #:_____

Address: _____
(If Different From Above) (City/Town/State) (Zip Code)

II. Other Coverage:

- Are any of your above-listed dependent(s) currently working? Yes: ___ No: ___
- Do any of your above-listed dependent(s) currently have, or are eligible for an employer-sponsored health Plan? Yes: ___ No: ___

If yes, please provide the following information:

- Subscriber's Full Name: _____
- Name of other Plan: _____
- Subscriber's ID or Policy Number: _____

Este aviso está disponible en español en el sitio de web www.mlbf.org

- Effective Date of Coverage: _____
- Single or Family Coverage: _____

Remember, if your dependent child, ages 19 to 26, is eligible for her/her own employment-based health coverage, the dependent child is not eligible for coverage under this Fund.

These completed forms must be received no later than the 20th of the month for coverage to be effective on the first day of the following month.

III. AUTHORIZATION AND ACKNOWLEDGEMENT OF DUTY TO PROVIDE ACCURATE AND COMPLETE INFORMATION AND UPDATE IT AS NECESSARY

I understand that I am enrolling myself, my spouse, and/or dependent(s) for coverage under the Massachusetts Laborers' Health and Welfare Fund effective July 1, 2011. I also understand that I am required to promptly notify the Fund of any changes in my status or the status of any of my dependents that would affect eligibility for benefits, including, but not limited to, any change in my marital status, any change in coverage for me, or any change in my dependent(s)' eligibility for coverage under this Fund or under any other medical plan or health insurance.

I understand that if I knowingly enroll (or continue the enrollment of) an ineligible dependent, I will be committing fraud on the Fund and acknowledge the Fund's right to recover any benefits that were inappropriately paid on behalf of the ineligible dependent. I may also be subject to additional penalties including suspension or termination of benefits. I swear or affirm under the penalties of perjury that the information I have provided on this Enrollment Form is complete and accurate.

Please Print Your Name_____

Please Sign Your Name _____

Date: _____

Social Security Administration

Form Approved
OMB No. 0960-0602

Authorization to Obtain Earnings Data from the Social Security Administration

Mail completed form to:	Social Security Administration Division Business Services PO Box 33011 Baltimore, MD 21290-3011	Requesting organization:	RA PENF 09 8588 MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND 14 N.E. EXECUTIVE PARK, SUITE 200 BURLINGTON MA 01803-5201

Number Holder's Information

First Name: Middle Initial:

Last Name:

SSN: -- --

Date of Birth: -- -- (Month / Day / Year) Date of Death: -- -- (Month / Day / Year)

Other First, Middle Initial, and Last Name Used to Report Earnings:

Periods Requested: -- through -- (Month / Year / Month / Year)

-- through -- (Month / Year / Month / Year)

I am the individual to whom the record/information applies or that person's parent (if a minor) or legal guardian, or a person who is authorized to sign on behalf of the individual to whom the record/information applies. Please furnish the requesting organization, or its designees, an itemized statement of all amounts of earnings reported to my record, or to the record identified above, for the periods specified on this form. Please include the identification numbers, names, and addresses of the reporting employers. **I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.**

Signature of Number Holder *(or authorized representative)*	Date -- --
Printed Name *(if other than number holder)*	Relationship *(if other than number holder)* ☐ Natural or adoptive parent ☐ Legal Guardian ☐ Other *(specify)* _____
Address / State	
City / ZIP Code	Phone Number

Requesting Organization's Information

Signature of Organization Official	Date
Phone Number	Fax Number

FOR SSA USE ONLY ☐1 ☐2 ☐3 ☐4

IMPORTANT INFORMATION

Privacy Act Statement

SSA 581 (Authorization to Obtain Earnings Data from the Social Security Administration)

Sections 205(a), 205(c)(2), and 223 of the Social Security Act, as amended, authorize us to collect the information requested on this form. We will use the information you provide to obtain your earnings data or the earnings data of a deceased individual. Your responses are voluntary. However, failure to provide us with the requested information could prevent us from processing your request.

We rarely use the information you give us for any purpose other than providing the earnings information you request. However, we may use the information for the efficient administration of our programs. We may also disclose information to another person or agency in accordance with approved routine uses, including but not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office, General Services Administration, the Department of Justice, and the Department of Treasury);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you give us in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave to us is available in our Privacy Act System of Records Notice entitled, Earnings Recording and Self-Employment Income System, 60-0059. Additional information about this and other systems of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security Office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 2 minutes to read the instructions, gather the facts, and answer the questions. ***Send only comments relating to our time estimate above to**: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.*

FONDO DE SALUD Y BIENESTAR DE LOS TRABAJADORES DE MASSACHUSETTS

14 NEW ENGLAND EXECUTIVE PARK • SUITE 200
BURLINGTON, MASSACHUSETTS 01803-5201
TELÉFONO (781) 272-1000 • GRATIS (800) 342-3792 • FAX 781-238-0703

FORMULARIO DE INSCRIPCIÓN

Por favor, use este formulario para inscribir a sus hijos(as) a su cargo entre las edades de 19 años a 26 años. Si su hijo a su cargo entre las edades de 19 a 26 es elegible para cualquier empleador patrocinado plan de seguro médico, entonces él/ella no es elegible para la cobertura de seguro médico del Fondo de Salud y Bienestar de los Trabajadores de Massachusetts.

Con el fin de inscribir a sus dependientes de 19 a 26 años de edad, usted debe completar la siguiente información, y su hijo o hija deben completar la autorización adjunta para obtener datos de la Administración del Seguro Social (Formulario SSA-581):

I. Nombre del Miembro: _____ # de Seguro Social:_____

Dirección: _____
(Calle) (Ciudad/Pueblo/Estado) (Código Postal)

Nombre del Dependiente: _____ # de Seguro Social: _____

Dirección: _____
(Si es Diferente) (Ciudad/Pueblo/Estado) (Código Postal)

Nombre del Dependiente: _____ # de Seguro Social: _____

Dirección: _____
(Si es Diferente) (Ciudad/Pueblo/Estado) (Código Postal)

II. Otra Cobertura:

- ¿Alguno de sus dependientes anteriormente mencionados en la lista está trabajando actualmente? Si: ___ No: ___
- ¿Alguno de sus dependientes anteriormente mencionados tiene actualmente, o son elegibles para un plan de salud patrocinado por el empleador? Si: ___ No: ___
  En caso afirmativo, sírvase proporcionar la siguiente información
  - Nombre Completo del Suscriptor: _____
  - Nombre del Otro Plan: _____
  - Identificación o número de póliza del suscriptor: _____

This notice is available in English on the website www.mlbf.org

- Fecha Efectiva de la Cobertura: _____
- Cobertura Individual o Familiar: _____

Recuerde, si su hijo(a) a cargo, entre 19 a 26 años, es elegible para su propia cobertura de seguro de salud con su propio empleador, el hijo(a) a su cargo no es elegible para la cobertura de este Fondo.

Estos formularios deben ser recibidos no más tarde del día 20 del mes para que la cobertura sea efectiva el primer día del mes siguiente.

III. AUTORIZACIÓN Y RECONOCIMIENTO DE LA OBLIGACIÓN DE PROPORCIONAR INFORMACIÓN EXACTA Y COMPLETA Y ACTUALIZARLA CUANDO SEA NECESARIO

Entiendo que me estoy inscribiendo a mí mismo, mi cónyuge y/o dependiente(s) para la cobertura del Fondo de Salud y Bienestar de los Trabajadores de Massachusetts en efecto desde el 1 de julio de 2011. También entiendo que tengo la obligación de notificar de inmediato al Fondo de cualquier cambio en mi situación o el estado de cualquiera de mis dependientes que podrían afectar la elegibilidad para beneficios, incluyendo pero no limitado a, cualquier cambio en mi estado civil, cualquier cambio en la cobertura para mí, o cualquier cambio en mi dependiente(s) elegibilidad para la cobertura de este Fondo o bajo cualquier otro plan médico o de seguro de médico.

Entiendo que si a sabiendas inscribirse (o continuo con la inscripción de) un dependiente inelegible, voy a estar cometiendo fraude al Fondo y reconocer el derecho del Fondo de recuperar los beneficios que se pagaron indebidamente en nombre de los dependientes ilegibles. También puedo estar sujeto a sanciones adicionales, incluyendo la suspensión o terminación de los beneficios. Juro o afirmo bajo pena de perjurio que la información que he proporcionado en esta solicitud de inscripción es completa y exacta.

Por Favor Escriba su Nombre _____

Por Favor Firme su Nombre _____

Fecha: _____

Social Security Administration

Form Approved
OMB No. 0960-0602

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Other First, Middle Initial, and Last Name Used to Report Earnings:

Periods Requested: Month -- Year through Month -- Year

Month -- Year through Month -- Year

I am the individual to whom the record/information applies or that person's parent (if a minor) or legal guardian, or a person who is authorized to sign on behalf of the individual to whom the record/information applies. Please furnish the requesting organization, or its designees, an itemized statement of all amounts of earnings reported to my record, or to the record identified above, for the periods specified on this form. Please include the identification numbers, names, and addresses of the reporting employers. **I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.**

Signature of Number Holder *(or authorized representative)*	Date -- --
Printed Name *(if other than number holder)*	Relationship *(if other than number holder)* ☐ Natural or adoptive parent ☐ Legal Guardian ☐ Other *(specify)* _____
Address / State	
City / ZIP Code	Phone Number

Requesting Organization's Information

Signature of Organization Official	Date
Phone Number	Fax Number

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1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office, General Services Administration, the Department of Justice, and the Department of Treasury);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of Social Security programs.

We may also use the information you give us in computer matching programs. Matching programs compare our records with records kept by other Federal, State, or local government agencies. We use the information from these programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or delinquent debts under these programs.

A complete list of routine uses of the information you gave to us is available in our Privacy Act System of Records Notice entitled, Earnings Recording and Self-Employment Income System, 60-0059. Additional information about this and other systems of records notices and our programs are available from our Internet website at www.socialsecurity.gov or at your local Social Security Office.

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