

Participant: _____

Ref #: _____

SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND OVERAGE DEPENDENT CERTIFICATION

I, _____ (*print name*), hereby make the following representations and agreements:

1. As of the date of this certification is made by me, I am at least 19 years of age but have not yet reached age 26.
2. As of the date this certification is signed by me, I am not eligible to participate (as defined below) in any employer-sponsored group health plan through my own employment.

Group health plan means any plan, policy, or program that provides benefits or coverage for hospital or medical services. **Eligible to participate** means that I could participate, but have chosen not to.

3. I agree that if I ever become eligible to participate in a group health plan (other than as a dependent of a plan of one of my parents) but I choose not to participate in that plan, I will promptly notify the Administrative Trust Funds Office at:

SOUTHERN CALIFORNIA IBEW-NECA HEALTH TRUST FUND

Attention: Membership Services Department

Office Location: 6023 Garfield Avenue
City of Commerce, CA 90040

Mailing Address: P O Box 910918
Los Angeles, CA 90091

Telephone: (323) 221-5861
Nationwide Toll Free: 1 (800) 824-6935
Fax: (323) 726-3520

4. I understand that if any time prior to age 26 I am eligible to participate in a group health plan (other than as a dependent of a plan of one of my parents) but I choose not to participate, then I cannot receive any benefits from the Southern California IBEW-NECA Health Trust Fund . Active Plan. If I receive such benefits while so eligible, I agree to promptly repay all such benefits to the Southern California IBEW-NECA Health Trust Fund. Further, if any lawsuit is brought against me to recover any portion of the afore-described benefits, I agree to pay the Southern California IBEW-NECA Health Trust Fund reasonable attorney's fees and costs in such lawsuit.

Signature of the Dependent

Date