



P.O. Box 4002 • Eau Claire, WI 54702-4002
715-835-3174 • 800-424-3405 • Fax 715-834-8061 • Claims Fax 715-835-3114

**Important Notice Concerning Coverage
For Children up to Age 26
Under the North Central States Regional Council
of Carpenters' Health Fund**

As part of the Patient Protection and Affordable Care Act (the Act), the North Central States Regional Council of Carpenters' Health Fund (the Plan) is required to provide coverage to eligible qualified children up to age 26. Coverage will be extended to the following:

- Children under age 26 who lost coverage because they met the Plan's previous dependent age restriction (age 23) or lost full time student status
- Children under age 26 who become eligible on or after January 1, 2011
- Children under age 26 who previously lost coverage and elected continuation coverage under COBRA

Extension of coverage under the Act applies to all children under age 26 regardless of whether they are dependent upon you for support or are married. The Act does not extend or provide coverage if the adult child has another offer of employer-based coverage (such as through his or her job). The Act also does not extend or provide coverage to your adult child's spouse or children.

If you have adult children who satisfy the provisions outlined in this Notice, please complete and return the enclosed election form if you wish to add them to your coverage.

Election forms will also be available from the Plan's website at www.ncscbf.com.

Board of Trustees
North Central States Regional Council of Carpenters' Health Fund

**North Central States Regional Council
of Carpenters Health Fund
Young Adult (Under Age 26) Election Form**

1. Participant Name _____
(Please print full name clearly)

2. Participant Address _____

3. Participant Identification Number _____

4. I wish to add the following children (under age 26) to my coverage:

<hr/> Print Dependent Child Name	<hr/> Print Date of Birth
<hr/> <i>Relationship (child/stepchild/married child)</i>	<hr/> <i>Employer of Dependent Child</i>

<hr/> Print Dependent Child Name	<hr/> Print Date of Birth
<hr/> <i>Relationship (child/stepchild/married child)</i>	<hr/> <i>Employer of Dependent Child</i>

<hr/> Print Dependent Child Name	<hr/> Print Date of Birth
<hr/> <i>Relationship (child/stepchild/married child)</i>	<hr/> <i>Employer of Dependent Child</i>

I hereby verify that the children listed above are my natural, adopted or stepchildren and that they have NOT been offered employer-based health coverage (through his or her job) or through their spouse's job.

5. Covered Participant's Signature _____

Date _____