CITYWIDE ASSOCIATION OF LAW ASSISTANTS OF THE CIVIL, CRIMINAL AND FAMILY COURTS IN THE CITY OF NEW YORK
WELFARE TRUST FUND
c/o Administrative Services Only, Inc. 303 Merrick Road, Suite 300, Lynbrook NY 11563

ADULT DEPENDENT CERTIFICATION FOR HEALTH COVERAGE

Should you wish a child age 19 or older and younger than age 26 to be covered under the Plan, this form must be **completed and signed** and returned to the Fund Office at the address above.

IMPORTANT NOTICE: This coverage is available even if the child is eligible to enroll in another employer sponsored plan. This means even if a child was offered coverage by his or her own employer, or his or her spouse's employer, then the parent's plan is still required to continue dependent coverage to age 26.

SECTION I PARTICIPANT INFORMATION

LAST NAME	FIRST NAME	SOCIAL SECURITY NUMBER -LAST 4 DIGITS
		___ ___ ___ ___

ADDRESS	APT NO.	CITY	STATE	ZIP

SECTION II ADULT DEPENDENT INFORMATION

COPIES OF BIRTH CERTIFICATES, ADOPTION CERTIFICATES, PROOF OF LEGAL GUARDIANSHIP OR YOUR NY SHIP CARD WITH YOUR DEPENDENT CHILD'S NAME MUST BE ATTACHED IF THEY ARE NOT ALREADY ON FILE WITH THE FUND OFFICE.

LAST NAME	FIRST NAME	DATE OF BIRTH	SEX	SOCIAL SECURITY NUMBER
			☐ M ☐ F	

ADDRESS	APT NO.	CITY	STATE	ZIP

DAY TIME PHONE NUMBER	EVENING PHONE NUMBER	EMAIL ADDRESS
( )	( )	

ARE YOU EMPLOYED?	IF YES, ARE YOU COVERED UNDER YOUR EMPLOYERS
☐ YES ☐ NO	DENTAL PLAN ☐ YES ☐ NO OPTICAL PLAN ☐ YES ☐ NO
ARE YOU MARRIED?	**IF YES, ARE YOU COVERED UNDER YOUR SPOUSE'S**
☐ YES ☐ NO	DENTAL PLAN ☐ YES ☐ NO OPTICAL PLAN ☐ YES ☐ NO

PLEASE READ AND SIGN REVERSE SIDE OF THIS FORM

CALA ADULT DEPENDENT CHILD CERTIFICATION FORM REVISED 2013 V.2

SECTION IV NOTIFY FUND OFFICE OF OTHER COVERAGE ELIGIBILITY:

You and/or your child shown above understand that you must notify the Fund as soon as the child becomes eligible (has the availability to secure) employer-sponsored health coverage with his/her employer. If the Fund Office is not notified (letter, fax or email) of other coverage/eligibility in a timely manner and claims are paid on the child's behalf, you and your child agree to promptly reimburse the Fund for any and all payments made on behalf of the child. If such reimbursements are not forthcoming, you understand that all future claim payments for you and/or any other enrolled dependents will be offset until full restitution is made. In addition, you understand that legal action may be taken by the Fund against you and/or your ineligible child to recover these ineligible claim payments, and you and your dependent agree to be jointly and severally liable for all such misdirected payments, plus interest and attorney fees, as applicable.

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 Fund, my child's eligibility for Fund coverage may be terminated retroactively and I will be liable for any claims that were paid erroneously based on the false or misleading information

____ / ____________________

Member's Signature Date

____ / ____________________

Dependent's Signature Date