IF YOU ARE NOT MAKING A CHANGE, YOU DO NOT NEED TO RETURN THIS FORM

2023 Annual Open Enrollment Form

Plan Year: January 1, 2023 to December 31, 2023

Iron Workers District Council of Philadelphia & Vicinity Health Benefit Plan
1807 Spring Garden Street, Philadelphia, PA 19130
215-537-0900 or 800-473-5005
iwdcpa.com

Open Enrollment is your opportunity to elect or waive coverage under the Plan and select the dependents you want to cover. Coverage for the plan option you select will start on January 1, 2023. You may only elect coverage during Open Enrollment if your HRA Account Credit balance is equal to or greater than three months of the cost of coverage for the plan option you elect. If you do not make an election for coverage, you will not be covered under the Plan. **You must complete and sign this form and return it to the Plan Office on or before November 30, 2022.**

INFORMATION ABOUT YOU

Member Name: (First Name, Middle Initial, Last Name, Suffix [e.g., "Jr."] if applicable)

Last 4 digits of Member's Social Security #:

Member Home Address - Street:		
City:	State:	Zip Code:
Home Phone:	Cell Phone:	Email:
Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced		Date of Birth:

YOUR HEALTH PLAN OPTION ELECTION*

Plan Option: ☐ Plan A ☐ Plan B ☐ Plan C ☐ Waive Coverage

Monthly Credit Cost: _____ (see chart on the back)

Coverage Tier: ☐ Member ☐ Member +1 ☐ Family

*Does NOT include Long-Term Disability, Life Insurance, and Waiver of Life Insurance Premium

INDIVIDUALS TO BE COVERED*

	Name (Last, First, Middle Initial)	Social Security #	Sex		Birthdate (mm/dd/yyyy)	Disabled, before age 26?	
			Male	Female		Yes	No
Self			☐	☐		☐	☐
Spouse			☐	☐		☐	☐
Dependent			☐	☐		☐	☐
Dependent			☐	☐		☐	☐
Dependent			☐	☐		☐	☐
Dependent			☐	☐		☐	☐

*If you have more dependents, use the back of this form.
**If you have a dependent who is disabled and became disabled prior to age 26, please contact the Fund Office.

If any of your dependents live at a different address than yours, please complete the following information for each of them.

Name(s)	Address(es)

Member Signature **Date**

By signing above, I hereby authorize the Credits in my HRA Program Account to be used to pay for the coverage election I have chosen. Further, my signature certifies that the information I have provided on this form is true and correct, and that I and my dependents listed on this form are entitled to the coverage I have chosen. I declare that all information and statements made herein are complete and true to the best of my knowledge. I understand that any misstatements or omissions may void all coverage applied for me and my dependents shown on this form. The Fund follows procedures to protect the privacy of the health information of all plan participants. The health plan's Privacy Notice summarizes those procedures and is available to you and your dependents. If you or your dependents are interested in receiving a copy of the Notice, please contact the Fund Office.

HEALTH PLAN OPTION MONTHLY CREDIT ELIGIBILITY REQUIREMENT			
	Member	**Member + 1**	**Member + Family**
Plan A	775 Credits	1,360 Credits	1,766 Credits
Plan B	634 Credits	1,098 Credits	1,420 Credits
Plan C	527 Credits	899 Credits	1,159 Credits

INDIVIDUALS TO BE COVERED *(continued)*

	Name (Last, First, Middle Initial)	**Social Security #**	**Sex**		**Birthdate (mm/dd/yyyy)**	**Disabled, before age 19?**	
			Male	**Female**		**Yes**	**No**
Self			☐	☐		☐	☐
Spouse			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐
Child			☐	☐		☐	☐