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

2026 Annual Open Enrollment Form

Plan Year: January 1, 2026 to December 31, 2026

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, 2026. 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 17, 2025.**

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 ☐ OPT Out

Coverage Tier: ☐ Member ☐ Member +1 ☐ Family

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

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	1390 Credits	1523 Credits	1600 Credits
Plan B	1223 Credits	1340 Credits	1408 Credits
OPT Out	250 Credits	250 Credits	250 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			☐	☐		☐	☐

BENEFICIARY DESIGNATION

Member Name: (First Name, Middle Initial, Last Name, Suffix [e.g., "Jr."] if applicable)	Date of Birth:	Social Security Number:

I hereby designate the person named below as my Beneficiary to receive benefits, if any, payable at my death under the Rules and regulations of this Fund.

Name of Beneficiary:

Last	First	Middle

Social Security Number:	Relationship to Member:

Address of Beneficiary - Street:

City:	State:	Zip Code:

In addition, I hereby designate the following person as my Contingent Beneficiary in case my above-named Beneficiary does not survive me.

Name of Contingent Beneficiary:

Last	First	Middle

Social Security Number:	Relationship to Member:

Address of Contingent Beneficiary - Street:

City:	State:	Zip Code:

I understand that I may change this Designation of Beneficiary at any time by filing again with the Fund Office another Designation of Beneficiary Form.

Signature	Date