

# ***SEAFARERS HEALTH AND BENEFITS PLAN***

5201 Auth Way  
Camp Springs, Maryland 20746-4275  
(301) 899-0675

Margaret R. Bowen  
Administrator

October 29, 2010

Dear Participant:

The Seafarers Health and Benefits Plan is pleased to inform you that effective on January 1, 2011, **the Plan will offer dependent health coverage to children up to age 26, provided that the child is not offered health coverage through his or her employer.** This new benefit is one of the changes that the Plan will be implementing to comply with the Patient Protection and Affordable Care Act. We will provide details in the near future about other changes that will take effect next year as a result of this law.

If you have a child who is currently under age 26 who lost coverage or who will lose coverage prior to January 1, 2011 because he or she reached age 19 and/or the child was not a full-time student; or a child who was never eligible for coverage, that child may now be eligible to enroll in the Seafarers Health and Benefits Plan. If you will be eligible for benefits in 2011, you may request enrollment for any such children by filling out the enclosed "Enrollment Form and Affidavit for Dependent Child." Please note, you must certify whether your child has access to other coverage through his or her employment, regardless of whether your child has actually elected to receive that coverage. The form must also be notarized.

Please fill out a copy of this form for each child that you wish to enroll. Additional copies are available on the Seafarers website – [www.seafarers.org](http://www.seafarers.org) - under the Member Benefits section; or you may photocopy the enclosed form. There is no cost to you for this coverage. To ensure coverage by January 1, 2011, you must return the completed form(s) no later than December 31, 2010 to:

Seafarers Health and Benefits Plan  
Attn: MAP Department  
5201 Auth Way  
Camp Springs, MD 20746

**Coverage for all eligible children who enroll by December 31, 2010 will begin on January 1, 2011. Coverage for eligible children who enroll after January 2011 will begin on the 1<sup>st</sup> of the month following the month in which the enrollment form is received. Please submit the form as soon as possible to ensure that your child is enrolled by January 1<sup>st</sup>.**

If you have any questions, please call the Claims Department at (800) 252-4674.

Sincerely,

Margaret R. Bowen  
Administrator



# SEAFARERS HEALTH AND BENEFITS PLAN

5201 Auth Way, Camp Springs, MD 20746  
Tel: (301) 899-0675 Fax: (301) 702-4435

For SHBP Official Use Only

Received Date: \_\_\_\_\_

Received By: \_\_\_\_\_

## ENROLLMENT FORM AND AFFIDAVIT FOR DEPENDENT CHILD

**TO BE COMPLETED BY THE PLAN PARTICIPANT FOR EACH CHILD  
BETWEEN THE AGES OF 19 AND 26**

**Seafarers Health and Benefits eligibility requirements for a dependent child are as follows:**

- A child, step-child, or foster child of an eligible participant who is less than twenty-six years of age and who does not have access to health coverage through his or her employer.
- The medical benefits for an eligible dependent shall cease once the dependent has reached age twenty-six or fails to meet the above eligibility requirements. **Note: You must advise the Plan office promptly if dependent status changes.**

**IN ORDER FOR THIS FORM TO BE ACCEPTED, YOU MUST ANSWER EVERY QUESTION**

### PARTICIPANT INFORMATION

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**PLEASE BE AWARE THAT YOU ARE REQUIRED TO NOTIFY THE PLAN OFFICE IMMEDIATELY IF ANY CHANGE IN DEPENDENT STATUS OCCURS. FAILURE TO DO SO MAY RESULT IN LOSS OF ELIGIBILITY FOR MEDICAL BENEFITS AND MAY REQUIRE REIMBURSEMENT OF ANY BENEFITS PAID FOR MEDICAL SERVICES ON DEPENDENT'S BEHALF.**

### DEPENDENT INFORMATION

Dependent Name: \_\_\_\_\_ SSN: \_\_\_\_\_ DOB: \_\_\_\_\_

If dependent does not have a SSN, provide Alien ID #: \_\_\_\_\_ OR I-94 #: \_\_\_\_\_

**ENCLOSE COPY OF SSA CARD OR OTHER CARD**

Address, if different from above: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is dependent employed?  Yes  No If yes, name of Employer: \_\_\_\_\_ Employer Phone Number: \_\_\_\_\_

Address of Employer: Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is your dependent offered health coverage through employment?  Yes  No Effective date of coverage, if elected: \_\_\_\_\_

### SIGNATURE

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### CERTIFICATION OF INFORMATION

I hereby attest that this child meets the eligibility requirements of a dependent in accordance with the Rules and Regulations of the Seafarers Health and Benefits Plan (the "Plan"). I hereby certify that the information contained herein is true. I agree to notify the Plan office of any changes that occur which may change my dependent's coverage. I further understand that if I make false statements I may jeopardize my Health Plan benefits and coverage and will be required to return any benefits paid for medical services under the Plan. I understand that the accuracy of the information contained herein as well as my compliance with the requirement to notify the Plan office of any changes that occur which may affect the status of my dependent's coverage under the Plan may be audited at any time by the Seafarers Plans Internal Auditor. In the event of such an audit, I may be required to provide additional information. I understand that my failure to provide the requested information may result in the loss of eligibility for medical benefits and/or the reimbursement of benefits that have been paid under the Seafarers Health and Benefits Plan.

### NOTARY PUBLIC

STATE OF \_\_\_\_\_ )

COUNTY OF \_\_\_\_\_ )

The foregoing instrument was acknowledged this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, by \_\_\_\_\_ (print name of participant), who personally appeared before me and acknowledged that he/she signed the instrument voluntarily for the purpose expressed in it.

Signature of Notary Public	NOTARY SEAL	<input type="checkbox"/> Personally Known
Print, Type, or Stamp Commissioned Name of Notary Public		<input type="checkbox"/> Produced Identification
Date Commission Expires: _____		Type of Identification: _____