ELIGIBILITY AND INITIAL ENROLLMENT

A. How To Enroll And Apply For Benefits

To receive prompt payment of benefits, you must follow these rules:

1. Enroll Yourself and Your Family

An **ENROLLMENT CARD,** listing your spouse and children under the age of 26 and designating your Beneficiary, must be on a file in the Fund Office. This card must be signed by you. **ANY CHANGE IN YOUR FAMILY STATUS (MARRIAGE, DIVORCE, BIRTH OF A CHILD, ETC.) MUST BE REPORTED TO THE FUND OFFICE.** You may change your Beneficiary at any time by filing a new Designation of Beneficiary card with the Fund Office.

Your dependents will not be enrolled in the Plan until you complete an Enrollment Card and send it along with all other required documentation, such as birth certificates and/or a marriage certificate, to the Fund Office. If you become Eligible for benefits and you enroll into the Plan but do not simultaneously enroll your dependents, your dependents will not be not be covered under the Plan until you send the Fund Office all required documents adding your dependents to the Plan. Coverage for your dependents will be effective retro-actively to the first date of eligibility.

2. Notification and Filing Time for Claims

a) Dental, Optical and Retiree Medical Claims must be received by the Fund Office within 12 months from the date of service (or the Medicare payment date for Retiree medical claims). No Bills or Claims will be honored if received more than twelve months after the services were rendered or Medicare's payment date.

b) Blue Cross claims must be received by Blue Cross within 18 months from the date of service

B. Initial Eligibility

To establish initial eligibility for coverage, you must have worked at least 1000 hours for one or more contributing employers during any twelve consecutive month period. Coverage will commence the month following the month that the 1,000 hours requirement was met during such twelve consecutive month period.

C. Eligible Dependents

Your legal spouse (unless legally separated or divorced) and all children (married and unmarried though coverage does not extend to spouses and children of children) under the age of 26, even if the young adult no longer lives with his or her parents, is not a dependent on a parent's tax return, or is no longer a student. Children include legally adopted children, stepchildren and foster children. Coverage will be continued for a child until the child attains age 26. Coverage for benefits will be provided for an unmarried dependent child, beyond age 26, provided he has been continuously incapable of self-support because of a mental or physical handicap that existed prior to age 26.

If you are eligible for benefits from the Fund, your dependents are eligible for all benefits provided to members (except Supplemental Unemployment, Vacation, Death, and Accidental Death and Dismemberment benefits). If your coverage for benefits terminates, coverage for your dependents will terminate.

D. Special Enrollment Rights

1. Special Enrollment Periods

This Plan provides special enrollment periods that allow you to enroll in the Plan without any extended restrictions even if you declined enrollment during an initial or subsequent eligibility period.

If you declined enrollment for yourself or your Dependents (including your spouse) because you had other health coverage, you may enroll for coverage for yourself and/or your Dependents if the other health coverage is lost. You must make written application for special enrollment within sixty (60) days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the Plan Administrator and apply for coverage by close of business on November 14.

If You are an eligible Employee or Dependent and you lose your Medicaid or state Children's Health Insurance Program coverage, also called CHIP, you have sixty (60) days to elect coverage under the Plan.

You or your eligible dependents may enroll during this special enrollment period if the person who wishes to enroll, called the "enrollee," meets all of the following conditions:

- The enrollee is eligible for coverage under the terms of this Plan;
- The enrollee is not currently enrolled under the Plan;
- When enrollment was previously offered, the enrollee declined because of coverage under another group health plan or health insurance coverage. You or the enrollee must have provided a written statement that other health coverage was the reason for declining enrollment under this Plan; and
- The other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

The enrollee is not eligible for this special enrollment right if:

- The other coverage was COBRA continuation coverage and the enrollee did not exhaust the maximum time available for that COBRA coverage; or
- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for the enrollee will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan.

2. Special Enrollment for New Dependents

If you acquire a new Dependent as a result of marriage, birth, adoption, or the placement of a child with you for adoption, you may be able to enroll yourself and your Dependents during a special enrollment period. You must make written application for special enrollment no later

than sixty (60) days after you acquire the new Dependent, excluding the day of the acquisition. For example, if you are married on September 15, you must notify the Plan Administrator and apply for coverage by close of business on November 14.

You may enroll yourself and/or your eligible Dependents during this special enrollment period if:

- You are eligible for coverage under the terms of this Plan, and
- You have acquired a new Dependent through marriage, birth, adoption or the placement of a child with you for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your Dependent(s) will be effective at 12:01 a.m.:

- For a marriage, on the first day of the calendar month following the date of marriage provided that the Fund Office receives the required employer contribution for the coverage.
- For a birth, the date of birth.
- For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

E. Continuing Eligibility

1. You will continue to be eligible for coverage during the coverage period beginning on April 1st of the current year and ending on March 31st of the following year if you worked 1,000 or more hours during the Calendar Year (January 1st to December 31st) prior to the April 1st starting date of the coverage period.
   - For example, if you earned 1,000 hours during the 2013 Calendar Year you will continue to be eligible during the coverage period beginning on April 1, 2014 and ending on March 31, 2015.
2. If you have worked at least 800 hours but less than 1,000 hours during a calendar year, you will be given the opportunity to continue your coverage during the coverage period beginning on April 1st of the following year on a direct payment basis by making contributions in the same amount as provided by the applicable collective bargaining agreement for Welfare Fund contributions for the difference between the number of hours for which contributions were made on your behalf and 1,000 hours, provided that:
   - You are available to work within the Industry at all times;
   - All payments to become eligible for a coverage period beginning April 1st are made to the Welfare Fund before April 1st of that year.
   - You are permitted to use this direct payment option for a maximum of two consecutive years. After the second consecutive year you may utilize the direct payment option again only after earning eligibility for coverage by working 1,000 hours during a calendar year. If you do not use the direct payment option or if after using the direct payment option for two consecutive years you do not earn coverage by working 1,000 hour, you retain the right to purchase COBRA.

MOSAIC & TERRAZZO WELFARE, PENSION AND SUPPLEMENTAL UNEMPLOYMENT BENEFIT FUNDS
45-34 Court Square • Long Island City, NY 11101
(718)729-4416 • Fax (718)729-4417

ADDRESS VERIFICATION CHANGE FORM

In order to have verification of your requested address change for our files, please complete the information below and send this form back to the Fund Office. The address change will not take place until the form has been returned to our office and we have the proper authorization, in writing, along with your signature.

I________________________________, authorize the Fund Office to make the
(Please Print Name)
following change effective as of ________________________.
(Date of Change)

____
SOCIAL SECURITY NUMBER

MY NEW ADDRESS IS:	**MY OLD ADDRESS WAS:**
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________
________________________	________________________
New Home Telephone Number	**Old Home Telephone Number**

____
Current Cell Phone Number

____
E-Mail Address

____
Member Signature

Notary Public________________________

Thank you,

Fund Office

Mosaic & Terrazzo Welfare Fund
45-34 Court Square
Long Island City, New York 11101
(718)729-4416

Coordination of Benefits Verification

If you or your dependent(s) are covered through Medicare or coverage for your dependent(s) is mandated by a court order, please call the Fund Office at 718-729-4416. Otherwise, please complete this form and return it to the Fund Office at the above address.

MEMBER / SPOUSE INFORMATION:

Member First Name________________________________ Last Name________________________________

Date of Birth ____________________________ Social Security #:________________________________

Spouse First Name ________________________________ Last Name________________________________

Spouse Date of Birth________________________ Spouse Social Security #:__________________________

OTHER COVERAGE INFORMATION (please circle one)

YES I or one of my dependents has coverage through another health insurance plan.

NO Neither I nor any of my dependents has coverage through any other health insurance plan.

IF YOU CIRCLED "YES" PLEASE COMPLETE THE OTHER HEALTH INSURANCE SECTION BELOW:

OTHER HEALTH INSURANCE

Policyholder's First Name________________________________ Last Name________________________________

Policyholder's Date of Birth__________________________ Relationship to Member__________________________

Other Health Insurance Company Name & Address ____

____ Telephone #______________________

Policy Number____________________________________ Effective Date______________________

Name & Address of Employer/Group that offers coverage: ____

Policyholder (please circle one): active employee retired employee

Type of coverage (please circle one): individual/single coverage family coverage

Benefits (please circle all that apply): Medical Hospitalization Prescription Dental Vision

List Name(s) of Family Members covered by this insurance____

____

Any member who improperly collects benefits from our Fund, based on misstatement or misrepresentation, will be legally liable for the return to our Fund of any improper Fund payments and legal action will be taken in all such cases. In addition the employee will be subject to suspension of all benefits, thereafter.

Members Signature____ **Date**__________________________

Do you or anyone enrolled as your dependent in the Empire Plan have any other group health insurance coverage? Other group health insurance coverage is coverage you have through another employer. It does not include Medicare coverage. If your only other coverage is Medicare, indicate NO, sign and return the questionnaire. If you have Medicare and other coverage, please indicate both.

☐ NO (Please sign and return questionnaire.)

☐ YES (Please answer questions 1–8, sign and return.)

1. Name of person with the other coverage:

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2. Birth date of person with other coverage:

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3. Name and address of employer/group that offers the other coverage:

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4. Name and address of their insurance company:

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5. Identification number and effective date of other coverage:

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6. Is the person indicated in #1 an ☐ active or ☐ retired employee?

7. Is the other coverage: ☐ individual ☐ family ☐ basic hospitalization ☐ major medical ☐ medical-surgical

8. Have you filed this request with the other insurance plan? ☐ Yes ☐ No

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature ____________________ Date ____________

SSC/COB-CLAIM

HIPAA AUTHORIZATION FORM

(To be used when authorizing the use and/or disclosure of personal health information.)

IMPORTANT INSTRUCTIONS: Please note that in order to constitute a valid authorization, items 1–4 must be completed and you must sign, date and have this document notarized.

1. Please fill in your name below and describe your Personal Health Information to be used or disclosed as a result of this authorization (i.e. do you wish to authorize a release of a specific claim, such as a surgery on a certain date, or related to a specific incident, such as an automobile accident on a certain date, etc.)
   Please Print Your Name Here ....______________________________
   Please describe your PHI Here.... ____
   ____
   ____

2. Please insert the name of the individual(s), group or entity authorized to request the use or disclosure of your Personal Health Information. If applicable, please check the box below and then fill in the name as to whom you wish to allow to request your Personal Health Information:

   [ ] Spouse   [ ] Doctor   [ ] Daughter   [ ] Son   [ ] Power of Attorney   [ ] Other

   Enter Name of Person Here: ____

3. Please insert to whom the Plan may release your Personal Health Information. If applicable, please check the appropriate box below and then fill in the name:

   [ ] Spouse   [ ] Doctor   [ ] Daughter   [ ] Son   [ ] Power of Attorney   [ ] Other

   Enter Name of Person Here: ____

4. This Authorization is valid for one year unless otherwise indicated here: __________________.

Right to Revoke - You have a right to revoke this authorization at any time in writing. There are two exceptions as follows:

1. If the information you authorized to be released has already been released.
2. If your authorization was required as a condition of obtaining the coverage.

Procedure to Revoke - To revoke this authorization you may either complete a new authorization form stating someone else is authorized or that no one is authorized to use and/or disclosure your PHI. Alternatively, you may submit a letter stating your intentions to revoke this authorization. In either case the revocation must be an original document, in writing and signed by you.

Note: The information covered by this authorization may be subject to redisclosure by the recipient of the personal health information and no longer covered by this rule.

______________________________   __________________
Signature   Date

NOTE: If the individual signing this document is a personal representative, please include documentation verifying your ability to act in the capacity of a personal representative.

NOTARY PUBLIC SECTION

The above named person signed this document before me this __________ day of ____________, 2013.
My commission expires ________________.

______________________________   __________________
Signature   Date