

**Second and Final Open Enrollment for
Adult Children Under Age 26 and Individuals
Who Have Exceeded the Plan's Lifetime Maximum
Deadline: September 1, 2011**

August 1, 2011

To: All Graphic Arts Participants and Dependents

The health care reform law known as the Patient Protection and Affordable Care Act (Affordable Care Act), among other things, requires that the St. Louis Graphic Arts Joint Health and Welfare Fund provide coverage for eligible children of plan participants until age 26 effective July 1, 2011. Coverage is available only to Adult Children who do not have other group health coverage available through their employment or through their spouse's employment, if married.

On May 31, 2011, the fund office sent a notice to all plan participants informing them of their right to enroll Adult Children under the Age of 26. There have been several phone calls from participants and dependents that did not understand the notice and did not enroll their Adult Children by the July 1, 2011 deadline. The Trustees have decided to offer a **second open enrollment with a deadline of September 1, 2011** for any Adult Child who missed the initial enrollment deadline of July 1.

In addition to covering your eligible adult children until their 26th birthday, this open enrollment period applies to anyone who meets the Plan's eligibility requirements even if that person previously exceeded the plan's lifetime maximum benefit limit. If you or a dependent previously exceeded the Plan's lifetime maximum and you are eligible to re-enroll please contact the Fund Office.

This is the **final notice** and no enrollment forms will be accepted for this open enrollment after the new September 1, 2011 deadline. Thereafter, enrollment of dependents will only be accepted in the case of a special enrollment event (see Section 1.1.5 of your November 1, 2006 Summary Plan Description).

Reminders:

The Fund no longer requires verification of full-time student status. In order to cover any dependent between ages 19 and 26, the enclosed enrollment form must be completed and returned to the Fund Office.

Even if you are not adding a new dependent you must return the form and provide the required information and documentation For ANY CHILD AGE 19 OR OLDER to be covered in the plan. Any child age 19 or older who is not listed on an enrollment form received by the Fund prior to September 1, 2011 will no longer be eligible for benefits.

Enclosed is an Adult Child Information Form which must be completed to re-enroll a person who reached the lifetime maximum or to enroll, re-enroll or continue coverage for a child age 19 or older.

Any child between the ages of 19 and 26 must complete and return the enclosed form prior to September 1, 2011 in order for coverage to be effective September 1, 2011.

The completed form must be signed and returned to the following address:

St. Louis Graphic Arts Joint Health & Welfare Fund
14323 South Outer Forty, Suite 106 South
Chesterfield, MO 63017

If you have any questions, please contact the Fund Office at (314) 878-1579.

Trustees of the
St. Louis Graphic Arts
Joint Health & Welfare Fund

St. Louis Graphic Arts Joint Health & Welfare Fund

Adult Child (Age 19-26) Enrollment Form

Due Date: September 1, 2011

Member Information		
Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Home Address:	City:	State:
Zip Code:	Phone Number:	
Spouse Information		
Last Name:	First Name:	Middle Initial:
Social Security Number:	Date of Birth:	
Home Address:	City:	State:
Zip Code:	Phone Number:	
Are you employed? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Employer:	
Address/Phone Number of Employer:		
Are you covered by another health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Plan:	
Address/Phone Number of Plan:		Group Number:
Are your dependents covered by this health plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	Maximum age for dependent coverage under this health plan?	

PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM

Adult Child Information			
Last Name:		First Name:	Middle Initial: Phone Number:
Social Security Number:		Date of Birth:	
Home Address:		City:	State: Zip Code:
Are you married? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of Spouse:	
Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, please complete this information	Are you eligible for health insurance coverage through your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Employer Name:	Employer Phone:	
	Employer Address:	City/State/Zip:	
	If you are employed, you MUST provide a letter, paycheck stub or other document from your current employer stating that either (a) health insurance is available to you through your own active employment or (b) health insurance is not available to you through your own active employment. This document must be on your employer's letterhead or show your employer's company logo.		
If you are married, is your spouse currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes, please complete this information	Are you eligible for health insurance coverage through your spouse's employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	Employer Name:	Employer Phone:	
	Employer Address:	City/State/Zip:	
	If your spouse is employed, you MUST provide a letter, paycheck stub or other document from your spouse's employer stating that either (a) health insurance is available to you through your spouse's active employment or (b) health insurance is not available to you through your spouse's active employment. This document must be on the letterhead of your spouse's employer or show the company logo of your spouse's employer.		
Are you eligible for coverage under any other employer-sponsored health plan besides a group health plan of either of your parents? <input type="checkbox"/> Yes <input type="checkbox"/> No If the answer to the above questions is yes, identify the other insurance carrier: _____; Policy Number: _____; Name of Policyholder: _____.			

I certify that:

- The listed Adult Child is eligible for coverage under the terms of the St. Louis Graphic Arts Joint Health & Welfare Fund.
- The information provided above is correct to the best of my knowledge, and I authorize the release of any information requested to the St. Louis Graphic Arts Joint Health & Welfare Fund.

I understand that the St. Louis Graphic Arts Joint Health & Welfare Fund will, from time to time, require updated certification, and that I must notify the Fund Office immediately of any change in the status of my Adult Child (i.e., eligibility for health coverage under any other medical insurance or self-insured plan, including that of an employer).

Signature of Member: _____ Date: _____

Signature of Spouse: _____ Date: _____

I certify that:

- I have reviewed the information contained on this form and that it is true and accurate.
- I will notify the above named Member in the event that I become eligible for coverage under any other employer sponsored health insurance or self-insured plan (other than those policies or plans sponsored by my parents' employer(s)).

I understand that the St. Louis Graphic Arts Joint Health & Welfare Fund will, from time to time, require updated certification, and that I must notify the Fund Office immediately of any change in my status as an Adult Child (i.e., eligibility for health coverage under any other medical insurance or self-insured plan, including that of an employer).

Signature of Adult Child: _____ Date: _____