THE HEALTH AND BENEFIT TRUST FUND OF THE INTERNATIONAL UNION OF OPERATING ENGINEERS LOCAL UNION NO. 94-94A-94B, AFL-CIO

Dependent Child Enrollment Form for the 2014 Enrollment Period

(If you are enrolling more than one child, you must complete a separate Enrollment Form for each child. If, however, your covered dependent children are currently enrolled in the Plan, you do not need to complete this form.)

1. I, the undersigned, am a participant in the Health and Benefit Trust Fund of the International Union of Operating Engineers Local Union No. 94-94A-94B, AFL-CIO (the "Plan").

2. I understand that, effective as of January 1, 2014, the Plan has been modified to cover eligible dependent children up to age 26, regardless of whether the child is eligible for other health insurance coverage, a student, married or unmarried, or a tax dependent of the participant, or any other factor than the relationship between the participant and child. I also understand that the Plan's Coordination of Benefits ("COB") rules apply to any dependent child who has other health insurance coverage. Generally speaking, under the Plan's COB rules, the plan that covers a person as an employee, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the person as a dependent pays second. Also, under the Plan's COB rules, the plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar years pays second. For further details about the Plan's COB rules, please refer to the Plan's Summary Plan Description.

3. I understand that the Plan's 2014 Enrollment Period ends on March 31, 2014 and, therefore, an Enrollment Form must be either hand-delivered to the Fund Office or postmarked and mailed by such date in order to enroll any new dependent child who presently is not covered by the Plan for coverage effective January 1, 2014. If I fail to enroll an otherwise eligible dependent child who currently isn't covered by the Plan by this March 31st deadline, I understand that such dependent child will not be covered by the Plan until the first day of the month following the date in which I provide the Fund Office with the completed Enrollment Form as well as any requested documentation for such child.

4. I hereby request enrollment of the following child:

   Name of Child:_____
   Date of Birth: _____
   SSN: _____
   Mailing Address:_____

5. I understand that I must immediately complete and submit a COB form to the Fund Office for any dependent child who is or becomes covered by other health insurance/coverage; and that the applicable COB rules under the Plan will apply with regard to the payment of all claims covered by this Plan and any other plan.

(Turn Over; and Complete and Sign Next Page)

Certification of Participant:

By signing this form, I confirm and certify that:

- My child, _____, does not have access to other health insurance/coverage. If my child is or becomes covered under another health insurance plan, I will immediately complete and provide a COB Form to the Fund Office to alert the Plan of such other coverage. I also agree to follow the applicable COB rules under the Plan and that all relevant benefit claims should be processed in accordance with such rules.

- I am required to immediately notify, in writing, the Fund Office if any statement made herein is no longer true or correct.

- If I apply for or continue coverage for anyone who is not eligible for coverage under the Plan or if I don't notify the Plan of my covered child's eligibility for other health insurance/coverage, this may be considered fraud or intentional misrepresentation and the coverage under the Plan may be rescinded or terminated to the extent permitted by law. In addition, I agree to be liable for any and all claims presented and paid by the Plan on behalf of (i) my ineligible dependent(s), or (ii) dependents for whom I did not inform the Plan of having other health insurance coverage and whose claims should have been covered, in part, by such other coverage in accordance with the Plan's COB rules.

_____ _____

Print Name of Participant Participant's SSN

_____ _____

Signature of Participant Date