AMERICAN MARITIME OFFICERS PLANS

MEDICAL – PENSION – MONEY PURCHASE BENEFIT – VACATION – SAFETY & EDUCATION – 401(K)

2 West Dixie Highway, Dania Beach, FL 33004 – 4312
Telephone: (954) 920-4247 or (800) 348-6515 Ext 14

July 26, 2010

RE: Trustees Approve Early Enactment of AMO Medical Benefit Changes

Dear Participant,

The Trustees of the American Maritime Officers Medical Plan have instructed the Plan Office to provide dependent child coverage up to age twenty-six effective August 1, 2010 (instead of the required date by law of October 1, 2010) as follows:

Effective August 1, 2010, the AMO Medical Plan will provide dependent coverage for each dependent child (married or unmarried) up to age nineteen, and for each dependent child (married or unmarried) who is nineteen years but less than twenty-six years of age and is attending school on a full-time basis. If your dependent child is not attending school on a full-time basis, the child may still be covered if he or she does not have access to health coverage through his or her employer.

If your child is currently not eligible for coverage because the availability of dependent coverage of children ended before the attainment of age twenty-six (including those currently on COBRA), or because he or she did not otherwise meet the requirements for dependent child coverage under the Plan, he or she is now eligible for enrollment. However, this does not apply to a child who has access to health coverage through his or her employer unless he or she is a full-time student.

Plan participants may request enrollment for their eligible dependents for coverage effective August 1, 2010, by submitting the attached “Affidavit for Dependent Child” form on or before September 30, 2010. Coverage for dependent children whose enrollment application is received after September 30, 2010, will be effective the first day of the month following the date the completed affidavit is received. Please note that additional information may be requested.

If you have any questions or require additional information, please contact the Medical Plan Office at (800) 348-6515, extension 12.

Sincerely,

Steven F. Nickerson
Executive Director

Enclosures (2):
“Additional Information Notice”
“Affidavit for Dependent Child” form

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ADDITIONAL INFORMATION REGARDING THIS NOTICE

The Plan office understands how difficult and time-consuming completing the required forms can be. In an effort to assist you with the enclosed notice, we are providing you with some additional information.

What does this change mean to our participants? Who is eligible?

Prior to August 1, 2010, the AMO Medical Plan covers:

- Each unmarried child who is under 19 years of age
- Each unmarried child who is 19 years but less than 23 years of age and attending school on a full-time basis

Effective August 1, 2010, the AMO Medical Plan will cover:

- Each dependent child (married or unmarried) up to the age of 19
- Each dependent child (married or unmarried) who is 19 years but less than 26 and is a full-time student
- Each dependent child (married or unmarried) who is 19 years but less than 26 years of age who is not a full-time student and who does not have access to health coverage through his or her employer.

What is the process to enroll a child?

The parent should complete the enclosed “Affidavit for Dependent Child” for each child that meets the eligibility requirements outlined above. A child will be covered on August 1, 2010, as long as the affidavit is received on or before September 30, 2010. Coverage for dependent children whose affidavit is received after September 30, 2010, will be effective the first day of the month following the date the affidavit is received.

If you are enrolling a child who has never been covered under the AMO Medical Plan you should also complete the “Coordination of Benefits for Dependent Spouse and Dependent Children” form. This form can be found at www.amoplans.com or you can contact the Medical Plan Office at (800) 348-6515, extension 12.

Who should complete the “Affidavit for Dependent Child”?

This form must be completed for all dependent children who are 19 years but less than 26 years of age and:

- Are attending school on a full-time basis or
- Are not a full-time student and do not have access to health coverage through his or her employer.

In the past I was always required to complete the "Affidavit of Support for Dependent Student" on an annual basis. Will I still be required to complete this form?

No, this form has been replaced with the "Affidavit for Dependent Child" form.

If you have previously submitted the "Affidavit of Support for Dependent Student" form, you are still required to submit the "Affidavit for Dependent Child" form. However, if we do not receive the "Affidavit for Dependent Child" form, your dependent child will be covered through the latest semester indicated on the last "Affidavit of Support for Dependent Student" form that was received by the Plan office.

Does my dependent child need to be a full-time student?

No. As long as your dependent child does not have access to health care through his or her employer, they will be eligible for medical coverage up to age 26.

What does full-time student mean?

Full-time student shall mean the completion of twelve credit hours per semester or its equivalent. Credits completed during summer or winter sessions may be applied to any one semester in a scholastic year.

Will my dependent child who is a full-time student still be eligible for the AMO Medical Scholarship Benefit?

Yes, if otherwise eligible, up to age 26 with a maximum of 4 scholarship benefits paid.

Will I be required to submit the "Affidavit for Dependent Child" on an annual basis?

No. However, you must advise the Plan Office promptly if dependent status changes.

Will I have to pay a premium to cover my child?

No, you will not have to pay anything to have your child covered.

Will a dependent child who previously reached the maximum age for coverage under the plan and elected COBRA continuation coverage be eligible to continue coverage under their parent's plan on August 1, 2010?

Yes. As long as the child meets the eligibility criteria stated above and the "Affidavit for Dependent Child" is received on or before September 30, 2010. If the affidavit is received after September 30, 2010, coverage will be effective the first day of the month following the date the affidavit is received.

When the child reaches age 26 and loses coverage under the plan, may the dependent child elect COBRA?

Yes, if otherwise eligible, the dependent child will be able to elect COBRA.

Where can I obtain additional forms?

Additional forms can be found online at www.amoplans.com or by calling the Medical Plan Office at (800) 348-6515, extension 12.

AMERICAN MARITIME OFFICERS (AMO) PLANS

2 West Dixie Highway, Dania Beach, FL 33004
Tel: (954) 920-4247 (800) 348-6515 Fax: (954) 920-9482 www.amoplans.com

For AMO Official Use Only
Received Date: ________
Received By: __________

AFFIDAVIT FOR DEPENDENT CHILD

TO BE COMPLETED BY THE PLAN PARTICIPANT FOR EACH CHILD BETWEEN THE AGES OF 19 AND 26 LISTED AS A DEPENDENT

Eligibility requirements for a dependent child are as follows:

- A child, step-child, or child under legal guardianship/custody of Participant who is nineteen years but less than twenty-six years of age and who is a full-time student.
- A child, step-child, or child under legal guardianship/custody of Participant who is nineteen years but less than twenty-six years of age and who is not a full-time student 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: XXX-XX-	DOB:

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 nave a SSN please explain why:			
Is dependent employed?	☐ Yes ☐No	☐ Part-Time ☐ Full-Time (30 hours or more per week).	
If yes, name of Employer:		Employer Phone Number:	
Address of Employer:			
City:		State:	ZIP Code:
Does your dependent have access to health coverage through employment?	☐ Yes ☐No	Effective date of coverage:	
Is your dependent a full-time student?	☐ Yes ☐No	Expected date of graduation:	

SIGNATURES	
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 AMO Medical 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 AMO Medical 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 AMO 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 AMO Medical 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 ____ Print, Type, or Stamp Commissioned Name of Notary Public ____ Date Commission Expires	NOTARY SEAL	❑ Personally Known ❑ Produced Identification Type of Identification: ____________________