OFFICE OF THE TRUSTEES LOCAL UNION NO. 710 HEALTH AND WELFARE FUND 9000 W. 187th Street Mokena, IL 60448

Date:

2018 ENROLLMENT FORM PLEASE COMPLETE IN ITS ENTIRET	TY FOR SPOUSE AND EACH DEPENDENT CHILD	
LEAGE COM LETE IN THE ENTINE	THOREST COOL AND LACTION LINDENT CHIED	
MEMBER NAME:	MEMBER ID#	MARITAL STATUS
MEMBER ADDRESS:		
MEMBER PHONE NUMBER:		
SPOUSE'S NAME:	DATE OF BIRTH:	_
	er	
Phone number of SPOUSE's employer		
Does your SPOUSE carry any group insuran-	ice? YES NO (IF YES, PLEASE INCLUDE BOTH SIDES OF	THE INSURANCE CARD)
Name of Insurance Company	ce within the last 12 months? □YES □NO	
Has your SPOUSE had any group insuran	ice within the last 12 months?	
Start date: End Date:	(If he/she no longer has insurance, plea	se submit a letter of cancellation
	from his/her previous insurance)	
	eck types of coverage on policy: □MEDICAL □DENTAL	□VISION □PRESCRIPTIONS
Please check whether single or family cov	verage: □SINGLE □FAMILY	
Is your spouse covered under a high-ded	ductible health plan with a health savings account?	Vac No
	leductible health plan, he/she will not be covered under t	
if your spouse is covered under a flight-d	reductible health plan, he/she will not be covered under t	ilis piali.
	DATE OF BIRTH:	
Phone number of child's employer	D. TIVES THE ATT THE PARTY OF THE PARTY STREET OF THE	LIE TNICHDANICE CARD)
	P □YES □NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE	TE INSUKANCE CARD)
Name of Insurance Company		
Has your child had any group insurance v		and the latter of and the con-
Start date: End Date:	(If they no longer have insurance, plea	ise submit a letter of cancellation

from his/her previous insurance)

□MEDICAL □DENTAL □VISION □PRESCRIPTIONS

__ Yes _____ No

I HEREBY CERTIFY THAT THE FORGOING STATEMENT INCLUDING ANY ACCOMPANYING STATEMENTS IS TRUE, CORRECT AND COMPLETE. GIVING FALSE INFORMATION IS A VIOLATION OF FEDERAL LAW.

If your child has insurance, please check types of coverage on policy: □MEDICAL □DENTAL □VISION □PRESCRIPTIONS

Member Signature Date

Is this adult child a full-time active member of the military or armed forces of any country? ☐YES ☐NO

If your child is covered under a high-deductible health plan, he/she will not be covered under this plan.

Is your child covered under a high-deductible health plan with a health savings account? __

If this adult child is married, does their spouse carry insurance? □NO

If yes, please include both sides of the insurance card

^{*}Failure to complete this in its entirety, may delay processing of claims for payment.

CHILD'S NAME: Name and address of child's employer Phone number of child's employer Does your child carry any group insurance? Name of Insurance Company Has your child had any group insurance with Start date: If your child has insurance, please check typ If this adult child is married, does their spouse If yes, please include both sides of the insurance Is this adult child a full-time active member of the Is your child covered under a high-deductib If your child is covered under a high-deductib If your child is covered under a high-deductib If HEREBY CERTIFY THAT THE FORGO	hin the last 12 months? □YES □NO (If they no longer have insurance, please submit a letter of cancellation from his/her previous insurance) pes of coverage on policy: □MEDICAL □DENTAL □VISION □PRESCRIPTIONS carry insurance? □NO □MEDICAL □DENTAL □VISION □PRESCRIPTIONS
CHILD'S NAME:	DATE OF BIRTH:
CHILD'S NAME: Name and address of child's employer Phone number of child's employer Does your child carry any group insurance? Name of Insurance Company Has your child had any group insurance witl	DATE OF BIRTH: DYES DNO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD) hin the last 12 months? DYES DNO
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CHILD'S NAME: Name and address of child's employer Phone number of child's employer	DATE OF BIRTH:
CHILD'S NAME:	DATE OF BIRTH:
	ole health plan with a health savings account? Yes No
If yes, please include both sides of the insurance is this adult child a full-time active member of the insurance is the same of the insurance in the insurance	ce card the military or armed forces of any country? □YES □NO
If this adult child is married, does their spouse	carry insurance?
If your child has insurance, please check ty	pes of coverage on policy: MEDICAL DENTAL VISION PRESCRIPTIONS
Start date: End Date:	(If they no longer have insurance, please submit a letter of cancellation from his/her previous insurance)
Has your child had any group insurance with	
Name of Insurance Company	
Phone number of child's employer	□YES □NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)
Name and address of child's employer	
CHILD'S NAME:	DATE OF BIRTH:
	tible health plan, he/she will not be covered under this plan.
Is your child covered under a high-deductib	ble health plan with a health savings account? Yes No
	the military or armed forces of any country?
If yes, please include both sides of the insurance	carry insurance? NO MEDICAL DENTAL VISION PRESCRIPTIONS ce card
	pes of coverage on policy: MEDICAL DENTAL DISTON PRESCRIPTIONS
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Phone number of child's employer Does your child carry any group insurance? E Name of Insurance Company Has your child had any group insurance with	□YES □NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)