

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

Date: _____

2019 ENROLLMENT FORM

PLEASE COMPLETE IN ITS ENTIRETY FOR SPOUSE AND EACH DEPENDENT CHILD

MEMBER NAME: _____ MEMBER ID# _____ MARITAL STATUS _____
MEMBER ADDRESS: _____ City _____ State _____ Zip Code _____
MEMBER PHONE NUMBER: _____
NAME OF MEMBER'S EMPLOYER: _____

SPOUSE'S NAME: _____ DATE OF BIRTH: _____

*Name and address of SPOUSE's employer _____ NOT EMPLOYED

Phone number of SPOUSE's employer _____

Does your SPOUSE carry any group insurance? YES NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)

Name of Insurance Company _____

Has your SPOUSE had any group insurance within the last 12 months? YES NO

Start date: _____ End Date: _____ (If he/she no longer has insurance, please submit a letter of cancellation from his/her previous insurance)

If your SPOUSE has insurance, please check types of coverage on policy: MEDICAL DENTAL VISION PRESCRIPTIONS
Please check whether single or family coverage: SINGLE FAMILY

Is your spouse covered under a high-deductible health plan with a health savings account? _____ Yes _____ No

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

CHILD'S NAME: _____ DATE OF BIRTH: _____

Name and address of child's employer _____

Phone number of child's employer _____

Does your child carry any group insurance? YES NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)

Name of Insurance Company _____

Has your child had any group insurance within the last 12 months? YES NO

Start date: _____ End Date: _____ (If they no longer have insurance, please submit a letter of cancellation from his/her previous insurance)

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

If this adult child is married, does their spouse carry insurance? NO MEDICAL DENTAL VISION PRESCRIPTIONS

If yes, please include both sides of the insurance card

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

Is your child covered under a high-deductible health plan with a health savings account? _____ Yes _____ No

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

I HEREBY CERTIFY AND AFFIRM THAT THE FOREGOING STATEMENT, INCLUDING ANY ACCOMPANYING DOCUMENTATION, IS TRUE, CORRECT AND COMPLETE. I UNDERSTAND THAT PROVIDING FALSE OR MISLEADING INFORMATION IS A VIOLATION OF APPLICABLE LAW AND MAY RESULT IN THE LOSS OF BENEFITS FOR ME AND FOR MY FAMILY.

Member Signature

Date

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

CHILD'S NAME: _____ DATE OF BIRTH: _____
Name and address of child's employer _____
Phone number of child's employer _____
Does your child carry any group insurance? YES NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)
Name of Insurance Company _____
Has your child had any group insurance within the last 12 months? YES NO
Start date: _____ End Date: _____ (If they no longer have insurance, please submit a letter of cancellation from his/her previous insurance)
If your child has insurance, please check types of coverage on policy: MEDICAL DENTAL VISION PRESCRIPTIONS
If this adult child is married, does their spouse carry insurance? NO MEDICAL DENTAL VISION PRESCRIPTIONS
If yes, please include both sides of the insurance card
Is this adult child a full-time active member of the military or armed forces of any country? YES NO

Is your child covered under a high-deductible health plan with a health savings account? _____ Yes _____ No
If your child is covered under a high-deductible health plan, he/she will not be covered under this plan.

CHILD'S NAME: _____ DATE OF BIRTH: _____
Name and address of child's employer _____
Phone number of child's employer _____
Does your child carry any group insurance? YES NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)
Name of Insurance Company _____
Has your child had any group insurance within the last 12 months? YES NO
Start date: _____ End Date: _____ (If they no longer have insurance, please submit a letter of cancellation from his/her previous insurance)
If your child has insurance, please check types of coverage on policy: MEDICAL DENTAL VISION PRESCRIPTIONS
If this adult child is married, does their spouse carry insurance? NO MEDICAL DENTAL VISION PRESCRIPTIONS
If yes, please include both sides of the insurance card
Is this adult child a full-time active member of the military or armed forces of any country? YES NO

Is your child covered under a high-deductible health plan with a health savings account? _____ Yes _____ No
If your child is covered under a high-deductible health plan, he/she will not be covered under this plan.

CHILD'S NAME: _____ DATE OF BIRTH: _____
Name and address of child's employer _____
Phone number of child's employer _____
Does your child carry any group insurance? YES NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)
Name of Insurance Company _____
Has your child had any group insurance within the last 12 months? YES NO
Start date: _____ End Date: _____ (If they no longer have insurance, please submit a letter of cancellation from his/her previous insurance)
If your child has insurance, please check types of coverage on policy: MEDICAL DENTAL VISION PRESCRIPTIONS
If this adult child is married, does their spouse carry insurance? NO MEDICAL DENTAL VISION PRESCRIPTIONS
If yes, please include both sides of the insurance card
Is this adult child a full-time active member of the military or armed forces of any country? YES NO

Is your child covered under a high-deductible health plan with a health savings account? _____ Yes _____ No
If your child is covered under a high-deductible health plan, he/she will not be covered under this plan.

I HEREBY CERTIFY AND AFFIRM THAT THE FOREGOING STATEMENT, INCLUDING ANY ACCOMPANYING DOCUMENTATION, IS TRUE, CORRECT AND COMPLETE. I UNDERSTAND THAT PROVIDING FALSE OR MISLEADING INFORMATION IS A VIOLATION OF APPLICABLE LAW AND MAY RESULT IN THE LOSS OF BENEFITS FOR ME AND FOR MY FAMILY.

Member Signature

Date