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

Date:

2023 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: _____ MEMBER E-MAIL ADDRESS _____
NAME OF MEMBER'S EMPLOYER: _____

SPOUSE'S NAME: _____ DATE OF BIRTH: _____
*Name and phone number of SPOUSE's employer_____☐NOT EMPLOYED
Spouse's Phone Number _____ Spouse's E-Mail Address _____
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 _____
Child over the age of 18: Phone number _____
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 ____
Child over the age of 18: Phone number ______________________
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 ____
Child over the age of 18: Phone number ______________________
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)
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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 ____
Child over the age of 18: Phone number ______________________
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
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____ ____________________
Member Signature **Date**