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 E	ACH DEPENDENT CHILD		
MEMBER NAME:	MEMPED ID #	MADT	
MEMBER ADDRESS:			
MEMBER ADDRESS			
NAME OF MEMBER'S EMPLOYER:			
SPOUSE'S NAME:	DATE O	F BIRTH:	
*Name and phone number of SPOUSE's employer			
Spouse's Phone Number Spouse's E Does your SPOUSE carry any group insurance? □YES □ Name of Insurance Company Has your SPOUSE had any group insurance within the	NO (IF YES, PLEASE INCLUDE	BOTH SIDES OF THE INSU	RANCE CARD)
Has your SPOUSE had any group insurance within the Start date:End Date:	(If he/she no longer has i	nsurance, please submit a	a letter of cancellation
	from his/her previous ins	-	
If your SPOUSE has insurance, please check types of o		AL DENTAL DVISION	I □ PRESCRIPTIONS
Please check whether single or family coverage:	INGLE DFAMILY		
Is your spouse covered under a high-deductible health If your spouse is covered under a high-deductible hea	Ith plan, he/she will not be c	overed under this plan.	
CHILD'S NAME:			
Name and address of child's employer			
Child over the age of 18: Phone number Does your child carry any group insurance?	(IF YES, PLEASE INCLUDE BO		NCE CARD)
Name of Insurance Company Has your child had any group insurance within the last			
Start date:End Date:		insurance please submit :	a letter of cancellation
	from his/her previous i		
If your child has insurance, please check types of cove			□PRESCRIPTIONS
If this adult child is married, does their spouse carry insura If yes, please include both sides of the insurance card	ance? NO MEDICAL	DENTAL VISION	
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 p If your child is covered under a high-deductible health			No
I HEREBY CERTIFY AND AFFIRM THAT THE FOREGOING S CORRECT AND COMPLETE. I UNDERSTAND THAT PROVID AND MAY RESULT IN THE LOSS OF BENEFITS FOR ME AN	DING FALSE OR MISLEADING I		

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 any group insurance? □YES □NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)
Name of Insurance Co	mpany
	ny group insurance within the last 12 months? \Box YES \Box NO
Start date:	End Date: (If they no longer have insurance, please submit a letter of cancellation
	from his/her previous insurance)
If this adult child is ma If yes, please include b	rance, please check types of coverage on policy: MEDICAL DENTAL VISION PRESCRIPTIONS rried, does their spouse carry insurance? MO MEDICAL DENTAL VISION PRESCRIPTIONS ooth sides of the insurance card
Is this adult child a full	-time active member of the military or armed forces of any country?
Is your child covered	under a high-deductible health plan with a health savings account? Yes No
	ed under a high-deductible health plan, he/she will not be covered under this plan.
CHILD'S NAME:	DATE OF BIRTH:
	child's employer
Child over the age of	18: Phone number any group insurance? □YES □NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)
	impany
	by group insurance within the last 12 months? \Box YES \Box NO
'	End Date: (If they no longer have insurance, please submit a letter of cancellation
	from his/her previous insurance)
If your child has insu	rance, please check types of coverage on policy:
	rried, does their spouse carry insurance? DNO DMEDICAL DENTAL VISION PRESCRIPTIONS
	both sides of the insurance card
Is this adult child a full	-time active member of the military or armed forces of any country?
	under a high-deductible health plan with a health savings account? Yes No
If your child is cover	ed under a high-deductible health plan, he/she will not be covered under this plan.
	DATE OF BIRTH:
	child's employer DATE OF BIRTH
	18: Phone number
Does your child carry	any group insurance?
	impany
	by group insurance within the last 12 months? \Box YES \Box NO
	End Date: (If they no longer have insurance, please submit a letter of cancellation from his/her previous insurance)
If your child has insu	rance, please check types of coverage on policy: MEDICAL DENTAL VISION PRESCRIPTIONS
If this adult child is ma	rried, does their spouse carry insurance? \Box NO \Box MEDICAL \Box DENTAL \Box VISION \Box PRESCRIPTIONS poth sides of the insurance card
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-time active member of the military or armed forces of any country?
	The active member of the minitary of armed forces of any country: ETES ENO
Is your child covered	under a high-deductible health plan with a health savings account? Yes No
If your child is cover	ed under a high-deductible health plan, he/she will not be covered under this plan.
	IFY AND AFFIRM THAT THE FOREGOING STATEMENT, INCLUDING ANY ACCOMPANYING DOCUMENTATION, IS TRUE
	COMPLETE. I UNDERSTAND THAT PROVIDING FALSE OR MISLEADING INFORMATION IS A VIOLATION OF
	W AND MAY RESULT IN THE LOSS OF BENEFITS FOR ME AND FOR MY FAMILY.

Member Signature