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

		Date:
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2025 ENROLLMENT FORM	AND FACIL DEPENDENT CHILD	
PLEASE COMPLETE IN ITS ENTIRETY FOR SPOUSI	E AND EACH DEPENDENT CHILD	
MEMBER NAME:	MEMBER ID#	MARITAL STATUS
MEMBER ADDRESS:		
MEMBER PHONE NUMBER:		
NAME OF MEMBER'S EMPLOYER:		
NAME OF MEMBER'S EMPLOTER.		
SPOUSE'S NAME:	DATE OF BIF	RTH:
*Name and phone number of SPOUSE's employ	er	■NOT EMPLOYED
Spouse's Phone Number Sp	ouse's E-Mail Address	
Does your SPOUSE carry any group insurance? I Name of Insurance Company	•	TH SIDES OF THE INSURANCE CARD)
Has your SPOUSE had any group insurance with	thin the last 12 months? □YES □NO	
Start date:End Date:		
	from his/her previous insurance	
If your SPOUSE has insurance, please check ty Please check whether single or family coverage		□DENTAL □VISION □PRESCRIPTIONS
Is your spouse covered under a high-deductible	e health plan with a health savings accou	nt? Yes No
If your spouse is covered under a high-deduction		
CHILD'S NAME.	DATE OF BIRTH.	
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?	ES INO (IF YES PLEASE INCLUDE BOTH S	IDES OF THE INSURANCE CARD)
Name of Insurance Company		
Has your child had any group insurance within		
Start date:End Date:		rance, please submit a letter of cancellation
	from his/her previous insura	
If your child has insurance, please check types	of coverage on policy: □MEDICAL □D	ENTAL DVISION DPRESCRIPTIONS
If this adult child is married, does their spouse ca		
If yes, please include both sides of the insurance		
Is this adult child a full-time active member of the	military or armed forces of any country? \square	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		
I HEDERY CERTIES AND ACCION THAT THE COR	ECOING STATEMENT INCLUDING ANY ACC	OMDANIVING DOCUMENTATION IS TOUT
I HEREBY CERTIFY AND AFFIRM THAT THE FORE CORRECT AND COMPLETE. I UNDERSTAND THA		
AND MAY RESULT IN THE LOSS OF BENEFITS FO		
Member Signature	Date	

Para obtener asistencia en Espanol, llame al 773-254-2500

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

CHILD	S NAME: DATE OF BIRTH:
	and address of child's employer
Child	ver the age of 18: Phone number
	our child carry any group insurance? □YES □NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)
	of Insurance Company
	ur child had any group insurance within the last 12 months? □YES □NO
Start o	ate:End Date:(If they no longer have insurance, please submit a letter of cancellation from his/her previous insurance)
If this	child has insurance, please check types of coverage on policy: MEDICAL DENTAL DVISION PRESCRIPTIONS
	adult child a full-time active member of the military or armed forces of any country? NO
Is you	child covered under a high-deductible health plan with a health savings account? Yes No
If you	child is covered under a high-deductible health plan, he/she will not be covered under this plan.
CUTLD	C NAME:
	S NAME: DATE OF BIRTH: and address of child's employer
	ver the age of 18: Phone number
Does	our child carry any group insurance?
	of Insurance Company ur child had any group insurance within the last 12 months? □YES □NO
	ate:End Date: (If they no longer have insurance, please submit a letter of cancellation
Start	from his/her previous insurance)
If this	child has insurance, please check types of coverage on policy: MEDICAL DENTAL DVISION PRESCRIPTIONS adult child is married, does their spouse carry insurance? MEDICAL DENTAL DVISION PRESCRIPTIONS please include both sides of the insurance card
	adult child a full-time active member of the military or armed forces of any country? NO
	child covered under a high-deductible health plan with a health savings account? Yes No child is covered under a high-deductible health plan, he/she will not be covered under this plan.
CHILD	S NAME: DATE OF BIRTH:
	and address of child's employer
Child Does	ver the age of 18: Phone numberour child carry any group insurance? \(\text{ TYES } \text{ INO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)}\)
	of Insurance Company
	ur child had any group insurance within the last 12 months? "YES "NO ate:End Date:(If they no longer have insurance, please submit a letter of cancellation from his/her previous insurance)
If you	child has insurance, please check types of coverage on policy: MEDICAL DENTAL DVISION PRESCRIPTIONS
If this	adult child is married, does their spouse carry insurance? MEDICAL DENTAL DISTON DIRECTIONS
	adult child a full-time active member of the military or armed forces of any country?
	child covered under a high-deductible health plan with a health savings account? Yes No child is covered under a high-deductible health plan, he/she will not be covered under this plan.
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	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