

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

Date:

2026 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: _____ ARE YOU ELIGIBLE FOR MEDICARE? ____YES ____NO

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
IS YOUR SPOUSE ELIGIBLE FOR MEDICARE? _____YES _____NO
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: _____
Child over the age of 18: Phone number _____ **E-mail** _____
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
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.
IS YOUR CHILD ELIGIBLE FOR MEDICARE? _____YES _____NO

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

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: _____

Child over the age of 18: Phone number _____ **E-mail** _____

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)

IS YOUR CHILD ELIGIBLE FOR MEDICARE? _____ YES _____ NO

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: _____

Child over the age of 18: Phone number _____ **E-mail** _____

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Name of Insurance Company _____

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If yes, please include both sides of the insurance card

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IS YOUR CHILD ELIGIBLE FOR MEDICARE? ___ YES ___ NO

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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: _____

Child over the age of 18: Phone number _____ **E-mail** _____

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