2018 ENROLLMENT FORM

FOX VALLEY & VICINITY LABORERS WELFARE AND PENSION FUNDS
2371 BOWES ROAD, SUITE 500 ELGIN, IL 60123-5523
Phone: 847-742-0900 Fax: 847-742-4430

RECEIPT OF THIS FORM BY FOX VALLEY WELFARE AND PENSION FUNDS DOES NOT GUARANTEE BENEFIT ELIGIBILITY
Failure to complete this form in full may result in delay of payment of claims.

SECTION 1 – MEMBER INFORMATION ONLY – *Must be completed in full and documents provided by member for coverage*

MEMBER: PLEASE ATTACH A COPY OF YOUR BIRTH CERTIFICATE AND SOCIAL SECURITY CARD ***(Please print clearly)***

Last Name ______________ First Name ______________ Middle Name ______________

Sex ☐ Male ☐ Female

Street Address ______________ City ______________

Phone No. (____) ____ - ______ Email: ______________ State ______ Zip ______

Date of Birth __ __ / __ __ / __ __ __ __ ***Attach a copy your of Birth Certificate***	Social Security # __ __ __ - __ __ - __ __ __ __ ***Attach a copy your of Social Security Card***	Union Local No. ________ City, State ______________

Participant Signature Here
(X) ______________________________ Date ____ / ____ / ____

It is fraudulent to fill out this form with information you know to be false or knowingly omit important facts. Criminal and/or Civil penalties can result from such an act.
If any of the above information is untrue, I agree to reimburse Fox Valley Laborers Health & Welfare Fund for any money it was induced to pay as a result of the information I provided.

SECTION 2 – Dependent Information – *Must be completed in full and **ALL DOCUMENTS LISTED MUST BE PROVIDED** for Welfare Coverage*

Your Marital Status: *check one box only*	☐ Single/ Not Married	☐ Married ☐ Remarried Date ____ / ____ / ____	☐ Widow ☐ Widower Date ____ / ____ / ____	☐ Separated Date ____ / ____ / ____	☐ Divorced Date ____ / ____ / ____

To enroll your Spouse fill in your spouse's name and attach a copy of your marriage certificate, your spouse's birth certificate and your spouse's Social Security card.

To enroll your Dependent Child: for EACH CHILD listed, provide name and Social Security No. and attach a copy of the birth certificate and Social Security card for EACH CHILD.

Spouse/Dependent Name(s) ***(PRINT CLEARLY)***	Social Security No./Birthdate	Relationship *(check ONLY one per dependent)*	Other Insurance
	SSN __ __ __ - __ __ - __ __ __ __ Birthdate __ __ / __ __ / __ __ __ __	☐ Spouse ☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter	☐ Yes ☐ No
	SSN __ __ __ - __ __ - __ __ __ __ Birthdate __ __ / __ __ / __ __ __ __	☐ Spouse ☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter	☐ Yes ☐ No
	SSN __ __ __ - __ __ - __ __ __ __ Birthdate __ __ / __ __ / __ __ __ __	☐ Spouse ☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter	☐ Yes ☐ No
	SSN __ __ __ - __ __ - __ __ __ __ Birthdate __ __ / __ __ / __ __ __ __	☐ Spouse ☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter	☐ Yes ☐ No
	SSN __ __ __ - __ __ - __ __ __ __ Birthdate __ __ / __ __ / __ __ __ __	☐ Spouse ☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter	☐ Yes ☐ No
	SSN __ __ __ - __ __ - __ __ __ __ Birthdate __ __ / __ __ / __ __ __ __	☐ Spouse ☐ Son ☐ Stepson ☐ Daughter ☐ Stepdaughter	☐ Yes ☐ No

☐ ***I have listed and attached additional dependent information on a separate sheet.***

(turn over this page to complete enrollment form)

Other Insurance – current or past *(Please print clearly)*

Is any member of your family covered by any other insurance plan ☐ Yes ☐ No or eligible for Medicare ☐ Yes ☐ No?

If NO, list termination date of other coverage (if applicable) _____/_____/_____ then sign and date this form below.

If YES, complete the following information, then sign and date below.

Name of person who has other insurance coverage or Medicare _____

Relationship _____ Birthdate __ __ / __ __ / __ __ __ __ SSN __ __ __ - __ __ - __ __ __ __

Does any other insurance plan cover your dependents ☐ Yes ☐ No?

If yes, please list all family members covered by other insurance. *Use an additional sheet if necessary.*

_____ _____ _____ _____

What type of coverage does this other insurance plan provide? ☐ Medical ☐ Dental ☐ Vision ☐ Other _____

Other Insurance Name _____ ***Please Print Clearly***

Address _____ City, State, Zip _____

Group/Plan No. _____ Effective Date _____/_____/_____

Primary Insured's Name _____ Insured's No. _____

Participant Signature Here Date _____/_____/_____ Spouse Signature Here Date _____/_____/_____

(X) _____ (X) _____

If any of the above coverage has terminated, list the type of coverage _____ and the termination date _____/_____/_____

Welfare Plan Beneficiary Designation *Please note: Benefits will be shared equally if not otherwise indicated below. (Please print clearly)*

I hereby designate the following named PRIMARY beneficiary(ies) as provided in the Welfare Plan:

(Benefits will be shared equally unless otherwise indicated.)

Name _____ Relationship _____ % of Benefit

Social Security No. __ __ __ - __ __ - __ __ __ __ Birthdate __ __ / __ __ / __ __ __ __ Phone (____) ____ - _____ _____%

Address _____

☐ I have listed and attached additional PRIMARY beneficiary information.

If none of the above-named beneficiary(ies) are living at the time of my death, I designate the following-named CONTINGENT beneficiary(ies):

(Benefits will be shared equally unless otherwise indicated.)

Name _____ Relationship _____ % of Benefit

Social Security No. __ __ __ - __ __ - __ __ __ __ Birthdate __ __ / __ __ / __ __ __ __ Phone (____) ____ - _____ _____%

Address _____

☐ I have listed and attached additional CONTINGENT beneficiary information.

Participant Signature Here (X) _____ Date ____ / ____ / ____

SECTION 3 – Pension Coverage – *Must be completed for Pension Coverage*

I hereby designate the following named beneficiary as provided in the Pension Plan: *If you name more than 1 person, benefits will be shared equally.*

Name _____ Relationship _____ % of Benefit _____%

Address _____

Social Security No. __ __ __ - __ __ - __ __ __ __ Birthdate __ __ / __ __ / __ __ __ __ Phone (____) ____ - _____

☐ I have listed and attached additional beneficiary information.

Participant Signature Here (X) _____ Date ____ / ____ / ____

*If you are married and wish to designate any beneficiary(ies) OTHER THAN YOUR SPOUSE, or your spouse shares in your pension benefits, your spouse **MUST** consent in writing to such designation and the consent must be witnessed by a Notary Public.*

I acknowledge and consent to the above beneficiary(ies) as designated. I also understand that as a result of the above beneficiary(ies) designation, I am not entitled to any benefits, upon my spouse's death, under the Plan. I understand that by my signature I am waiving my right to benefits in which I am otherwise entitled by law.

Spouse Signature Here Date ____ / ____ / ____

Notary Signature/Stamp Date ____ / ____ / ____

(X) _____ (X) _____