



# 2019/2020 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 ____ / ____ / ____ <i>Attach a copy your of Birth Certificate</i>	Social Security # ____ - ____ - ____ <i>Attach a copy your of Social Security Card</i>	Union Local No. _____ City, State _____
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Participant Signature Here \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
**(X)** \_\_\_\_\_

*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:  Single/Not Married  Married  Widowed  Widower  Separated  Divorced

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ 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
First Name _____ Last Name _____	Middle Name _____	SSN ____ - ____ - ____ Birthdate ____ / ____ / ____	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter	<input type="checkbox"/> Yes <input type="checkbox"/> No
First Name _____ Last Name _____	Middle Name _____	SSN ____ - ____ - ____ Birthdate ____ / ____ / ____	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter	<input type="checkbox"/> Yes <input type="checkbox"/> No
First Name _____ Last Name _____	Middle Name _____	SSN ____ - ____ - ____ Birthdate ____ / ____ / ____	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter	<input type="checkbox"/> Yes <input type="checkbox"/> No
First Name _____ Last Name _____	Middle Name _____	SSN ____ - ____ - ____ Birthdate ____ / ____ / ____	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter	<input type="checkbox"/> Yes <input type="checkbox"/> No
First Name _____ Last Name _____	Middle Name _____	SSN ____ - ____ - ____ Birthdate ____ / ____ / ____	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter	<input type="checkbox"/> Yes <input type="checkbox"/> No
First Name _____ Last Name _____	Middle Name _____	SSN ____ - ____ - ____ Birthdate ____ / ____ / ____	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter	<input type="checkbox"/> Yes <input type="checkbox"/> No
First Name _____ Last Name _____	Middle Name _____	SSN ____ - ____ - ____ Birthdate ____ / ____ / ____	<input type="checkbox"/> Spouse <input type="checkbox"/> Son <input type="checkbox"/> Stepson <input type="checkbox"/> Daughter <input type="checkbox"/> Stepdaughter	<input type="checkbox"/> Yes <input type="checkbox"/> 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)** \_\_\_\_\_