PLUMBERS & PIPEFITTERS LOCAL 101
HEALTH AND WELFARE FUND
137 Iowa Avenue
Belleville, IL 62220

FOR OFFICE USE ONLY
Effective Date:

ENROLLMENT FORM

Enrollment Data for MEMBER	Please type or neatly print all responses.		
Full Name: (Last)	(First)		(Middle)
Home Address: (Street)	(City)	(State)	(ZIP)
Social Security Number:	**Date of Birth:** (MM/DD/YY)	**Sex:** ☐ Male ☐ Female	**Marital Status:** ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Legally Separated

If you are DIVORCED or LEGALLY SEPARATED, please submit a copy of the decree showing effective date and responsibility for health coverage for children (if applicable).
If you are SINGLE, but have dependent children, please submit a Qualified Medical Child Support Order, along with a birth certificate for each child.

Are you covered under any other medical or dental insurance?	☐ Yes ☐ No
If "Yes", please list the following information:	Name of Insurance Carrier:
	Carrier Address:
	Policy Number:

Enrollment Data for DEPENDENTS

To enroll your spouse and other dependents, please fill in the information shown below for each dependent you wish to cover. Please submit a copy of your marriage certificate and/or your children's birth certificate(s). For children between the ages of 19 and 23, please submit verification of full-time student status.

Full Name (Last) (First) (MI)	**Date of Birth** (MM/DD/YY)	**Relationship to insured**	**Sex**	**Social Security Number**	**Address** (if different than member's address)	**Other Insurance?***
		Spouse	☐ M ☐ F			☐ Y ☐ N
			☐ M ☐ F			☐ Y ☐ N
			☐ M ☐ F			☐ Y ☐ N
			☐ M ☐ F			☐ Y ☐ N
			☐ M ☐ F			☐ Y ☐ N
			☐ M ☐ F			☐ Y ☐ N
			☐ M ☐ F			☐ Y ☐ N
			☐ M ☐ F			☐ Y ☐ N

***If you answered "Yes" to your dependents having other coverage, please fully complete the information on the reverse.**

I, the undersigned, confirm that the above information is true and current to the best of my knowledge. I certify that all the dependents I have listed above are eligible dependents under the terms of the plan and are eligible to be claimed by me as a dependent for Federal Income Tax purposes. I hereby authorize the release by or to Benefit Consultants, Inc. of any protected health information necessary to process claims and pay benefits for me and/or my dependents.

Signature of Member:	**Date:**

Please provide this information if you answered "Yes" to the "Other Insurance?" question in the Dependent Enrollment section.

Additional Dependent Coverage	Name of Dependent:
	Name of Insurance Carrier:
	Address of Carrier:
	Policy Number:

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