PLUMBERS & PIPEFITTERS LOCAL 101
HEALTH AND WELFARE FUND
4600 46th Avenue / Rock Island, IL 61201
(309) 794-1170 #2 or (800)-258-8923

FOR OFFICE USE ONLY
Effective Date:

INSURANCE ENROLLMENT FORM

Enrollment Data for MEMBER	**Please type or neatly print all responses. / Contact Email Address:**

Last Name: **First Name:** **Middle Initial:** **PHONE NUMBER:** **CELL PHONE:**
SPOUSE CELL PHONE:

Home Address: (Street) (City) (State) (ZIP)

Social Security Number:	**Date of Birth:**	**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 for each child.

Is spouse covered under any other medical or dental insurance due to employment?	☐ Yes ☐ No	**Please mark if spouse's insurance is Single/Family Coverage S_____ F _____**

If "Yes", please list the following information:	Name of Insurance Carrier:
	Carrier Address:
	Policy Number: Phone 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 **certified** copy of your marriage certificate and/or your children's birth certificate(s). For eligibility of **children between the ages of 19 and 26, please request an Adult Child Enrollment form**. ****NOTE: IF THIS IS AN ENROLLMENT UPDATE YOU DO NOT NEED TO PROVIDE MARRIAGE OR BIRTH CERTIFICATES FOR DEPENDENTS FOR WHOM THEY WERE PREVIOUSLY PROVIDED TO THE FUND OFFICE.****

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 page 2.**

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 Plumbers & Fitters Local 101 Welfare Fund 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:	Phone Number:

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	Name of Insurance Carrier:	
	Address of Carrier:	
	Policy Number:	Phone Number: