PLUMBERS & PIPEFITTERS LOCAL 101
HEALTH AND WELFARE FUND

1903 52nd AVENUE
MOLINE, IL 61265
(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			
Full Name:	**Last**	**First**	**Middle Initial**	**Home Phone:** **Cell:** **Spouse Cell:**
Member Email	**Spouse Email**	**Additional Contact Information:**		
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, dental or prescription insurance due to employment?	☐ Yes ☐ No	**Please mark if spouse's coverage is Single/Family Coverage S____ F____**
Spouse Employment Information:	Name of Employer::	
Date of Hire:	Employer Address:	
	HR Contact Person:	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

***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:**
Signature of Spouse:	**Date:**