2019/2020 ENROLLMENT FORM

FOX VALLEY AND 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 __ __ / __ __ / __ __ __ __	Social Security # __ __ __ - __ __ - __ __ __ __	Union Local No.	City, State
Attach a copy of your birth certificate	*Attach a copy of your Social Security card*	__________	______________________

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 and 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	☐ Widow ☐ Widower	☐ Separated	☐ Divorced
		Date ____ / ____ / ____	Date ____ / ____ / ____	Date ____ / ____ / ____	Date ____ / ____ / ____

To enroll your Spouse: Please provide your spouse's name, Social Security No. and birthdate. Please attach a copy of your marriage certificate, your spouse's birth certificate and your spouse's Social Security card.

To enroll your Dependent Child: Please provide **EACH DEPENDENT CHILD'S** name, Social Security No. and birthdate. For **EACH CHILD** listed below, please attach a copy of each child's birth certificate and Social Security card**.**

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

(X) _____ ____ / ____ / ____

SECTION 3 – Pension Plan Beneficiary Designation *Please note: Benefits will be shared equally if not otherwise indicated below. (Please print clearly)*

I hereby designate the following named beneficiary as provided in the Pension Plan: *If you name more than one 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 Date

(X) _____ ____ / ____ / ____

*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.

Notary Signature/Stamp Date _____ / _____ / _____

Spouse Signature Here Date _____ / _____ / _____

(X) _____ **(X)** _____