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 Email: customerservice@fvlab.com

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.

PARTICIPANT INFORMATION – *Must be completed in full and all documents must be provided by Participant for Welfare 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*		

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 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.

Participant Signature Here
(X) ____________________

Date ______ / ______ / ______

DEPENDENT INFORMATION – *Must be completed in full and all documents 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 date of birth. 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 date of birth. 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. / Date of Birth**	**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.**

(Please complete Enrollment Form on reverse side)

GCC/IBT

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 coverage? ☐ Yes ☐ No

If No, list termination date of other coverage (if applicable) _____/_____/_____

If Yes, provide the following information:

Name of person who has other insurance coverage or Medicare coverage: _____

Relationship _____ Date of Birth __ __ / __ __ / __ __ __ __ 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 ☐Prescription 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:

Name _____ Relationship _____ % of Benefit

Social Security No. __ __ __ - __ __ - __ __ __ __ Date of Birth __ __ / __ __ / __ __ __ __ Phone (____) _____ - _____ _____%

Address _____

E-mail _____

☐ I have listed and attached additional **PRIMARY** beneficiary information. ☐ I have listed and attached **CONTINGENT** beneficiary information.

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 PRIMARY beneficiary(ies) as provided in the Pension Plan:

Name _____ Relationship _____ % of Benefit

Social Security No. __ __ __ - __ __ - __ __ __ __ Date of Birth __ __ / __ __ / __ __ __ __ Phone (____) _____ - _____ _____%

Address _____

E-mail _____

☐ I have listed and attached additional **PRIMARY** beneficiary information. ☐ I have listed and attached **CONTINGENT** beneficiary information

Participant Signature _____ **Date** _____/ _____/ _____

** If you are married and designate any beneficiary(ies) OTHER THAN YOUR SPOUSE, your spouse must consent in writing (below) to such designation(s) and the consent must be witnessed by a Notary Public.*

**** SPOUSAL CONSENT (if necessary):***

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 under the Plan upon my spouse's death. I understand by signing below I am waiving any rights to benefits in which I may otherwise be entitled to by law.

Spouse Signature: **Date** _____/ _____/ _____ **Notary Signature:** **Date** _____/ _____/ _____

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

Notary Stamp Here: