

**PLUMBERS & PIPEFITTERS LOCAL 101
HEALTH AND WELFARE FUND
8 Premier Drive
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: <input type="checkbox"/> Male <input type="checkbox"/> Female	Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> 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.			

Are you covered under any other medical or dental insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> 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 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.						
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	<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> N
			<input type="checkbox"/> M <input type="checkbox"/> F			<input type="checkbox"/> Y <input type="checkbox"/> 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 J.W. Terrill, Inc. of any protected health information necessary to process claims and pay benefits for me and/or my dependents.

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

<i>Additional Dependent Coverage</i>	Name of Dependent:
	Name of Insurance Carrier:
	Address of Carrier:
	Policy Number:

<i>Additional Dependent Coverage</i>	Name of Dependent:
	Name of Insurance Carrier:
	Address of Carrier:
	Policy Number:

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

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

<i>Additional Dependent Coverage</i>	Name of Dependent:
	Name of Insurance Carrier:
	Address of Carrier:
	Policy Number:

<i>Additional Dependent Coverage</i>	Name of Dependent:
	Name of Insurance Carrier:
	Address of Carrier:
	Policy Number: