# Central States Joint Board Health & Welfare Trust Fund

1950 West Erie Street ~ Chicago, Illinois 60622 ~ 312-738-0822 or 1-800-258-6466

## Enrollment Form

***Please complete, sign, and return this form to the Fund Office. Please print all information.***

## Employee Information

Employee Full Name: _____ Employee SS#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Date of Birth: _____ Shop:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

## Coverage Level Election

I elect the following coverage level under the Central States Joint Board Health & Welfare Trust Fund:

☐ Employee Only, with a monthly contribution rate of $

☐ Employee Plus Children, with a monthly contribution rate of $

☐ Employee Plus Spouse, with a monthly contribution rate of $.

☐ Employee Plus Family (Spouse and Child(ren)) , with a monthly contribution rate of $

## Dependent Information

Provide all information for eligible dependents to be covered under the Plan (attach additional page, if necessary).

| Full Name (First, MI, Last) | Relationship | Sex F | Sex M | Social Security Number | Date of birth | Check if Employed |
|---|---|---|---|---|---|---|
| | | ☐ | ☐ | | ___ ___ ___ | ☐ |
| | | ☐ | ☐ | | ___ ___ ___ | ☐ |
| | | ☐ | ☐ | | ___ ___ ___ | ☐ |
| | | ☐ | ☐ | | ___ ___ ___ | ☐ |

## Employee Authorization

I understand that if I elect not to cover a dependent at this time, I will not be able to enroll my dependent until the next enrollment period, unless a special enrollment is necessary. By selecting a coverage level, signing, and submitting this form, I understand this election will remain in effect until the end of the calendar year for which this form is signed and I authorize the applicable contribution rate for this coverage, if any, be deducted from my paycheck. I understand that by electing coverage for a dependent child, I am certifying that the dependent child is not eligible for insurance coverage through his/her employer or through his/her spouse's employer. Moreover, I certify that I will promptly advise the Central States Joint Board Health & Welfare Fund if my dependent child's employer or his/her spouse's employer offers health coverage even if my dependent child elects not to receive coverage through his/her employer or his/her spouse's employer. **I hereby certify that the information on this form, to the best of my knowledge and belief, is true, correct, and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment.**

Employee Name (print): _____

Employee's Signature: _____ Date: _____

Completion of this enrollment form is not a guarantee of eligibility or benefits.

_____ Initials of Company Representative for approval of enrollment form due to change, addition or open enrollment.

Employee Name: _____ SSN: _____

| Full Name | Relationship | Sex<br>F M | Social Security Number | Date of Birth | Check if Employed |
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## Adult Dependent Child Authorization (Ages 19-26)

I understand that my parent is seeking to enroll me for benefits under the Central States Joint Board Health & Welfare Fund. By signing below, I hereby certify that I am not eligible to enroll in any employer-sponsored health plan. I understand that this means that neither my employer nor my spouse's employer offers coverage to me regardless of the costs. Moreover, I certify that I will promptly advise the Central States Joint Board Health & Welfare Fund if my Employer or my spouse's employer offers health coverage even if I elect not to receive coverage through my employer of my spouse's employer. **I hereby certify that the information on this form, to the best of my knowledge and belief, is true, correct, and complete. I understand any willfully false statement on this form is a federal crime that is punishable by fine or imprisonment. Mail to Central States Joint Board Health & Welfare Fund 1950 W. Erie Chicago, IL 60622 OR Fax to 312-455-8857.**

*Employee's Name:*_____

*Employee's SS#*_____

Dependant's Name (print): _____

Employer's Name: _____

Employer's Insurance Company: _____

Spouse's Name: _____

Spouse's Employer's Name: _____

Spouse's Employer's Insurance Company: _____

Dependent Child's Signature: _____ Date: _____

Completion of this enrollment form is not a guarantee of eligibility or benefits.