THE NORTH CENTRAL ILLINOIS LABORERS' HEALTH & WELFARE FUND

4208 W PARTRIDGE WAY, UNIT 3
PEORIA, IL 61615

ENROLLMENT / CHANGE FORM

EMPLOYMENT STATUS: ☐ACTIVE ☐RETIRED ☐SURVIVING SPOUSE ☐COBRA | LABORERS' LOCAL # _____

A. MARK PLAN OF CHOICE

☐BLUE CROSS BLUE SHIELD ☐CIGNA ☐SWITCHED HEALTH PLANS TO: _____

B. MEMBER DEPENDENT CHANGE

☐INITIAL ENROLLMENT ☐ADDRESS/PHONE CORRECTION
☐OPEN ENROLLMENT ☐DELETE DEPENENT (S)
☐ADD DEPENDENT (S)
☐NAME CHANGE: FORMER NAME: _____

C. MARITAL STATUS

☐MARRIED ☐SINGLE
☐DIVORCED ☐LEGALLY SEPERATED
☐WIDOWED

D. MEMBER INFORMATION

NAME (LAST, FIRST, MIDDLE) | MAIDEN NAME OF APPLICANT OR SPOUSE:

MAILING ADDRESS | CITY | STATE | ZIP

SEX ☐MALE ☐FEMALE	SOCIAL SECURITY NUMBER	AGE	DATE OF BIRTH	TELEPHONE NUMBER

E. FAMILY INFORMATION

List all family members to be covered. Please print name. Please attach copies of all documentation needed: e.g. birth certificates, marriage certificate, adoption paperwork, divorce decree, etc… Please use extra paper if additional room is needed.

NAME (LAST, FIRST, MIDDLE)	SOCIAL SECURITY NUMBER	RELATION	DATE OF BIRTH	SEX
				☐M ☐F
				☐M ☐F
				☐M ☐F
				☐M ☐F
				☐M ☐F
				☐M ☐F
				☐M ☐F

F. OTHER HEALTH INSURANCE INFORMATION ** THIS SECTION MUST BE COMPLETED **

On the day your coverage begins will any family members be covered by another health plan, Medicare, Medicaid? ☐YES ☐NO If yes, fill out this section. Use extra paper if more than one additional policy will be in force.

COVERAGE TYPE : ☐MEDICAID ☐MEDICAL INSURANCE ☐MEDICARE | MEDICARE ELIGIBILITY DUE TO: ☐KIDNEY FAILURE ☐DISABILITY ☐AGE

INSURANCE COMPANY NAME AND NUMBER	POLICY NUMBER	POLICY COVERAGE DATES TO

NAME OF POLICY HOLDER	DATE OF BIRTH	FAMILY MEMBERS COVERED

EMPLOYER NAME	EMPLOYERS ADDRESS	EMPLOYERS PHONE NUMBER

MEDICARE COVERED FAMILY MEMBERS	MEDICARE ID NUMBER	PART A. EFFECTIVE DATE	PART B. EFFECTIVE DATE

IS YOUR SPOUSE EMPLOYED? ☐YES ☐NO IF YES, IS HEALTH INSURANCE OFFERED? ☐YES ☐NO

NAME, ADDRESS AND PHONE NUMBER OF SPOUSES' EMPLOYER

G. CERTIFICATION

I, the undersigned applicant, apply for the healthcare coverage offered under the Plan of benefits established by the Plan Sponsor, for myself and any of my eligible dependnets listed on this application. I certify and affirm that all statements made in this Ernollment/Change Form are true.

Date: Applicant's Signature