North Central Illinois Laborers' Health and Welfare Fund

4208 W. Partridge Way • Unit 3
Peoria, IL 61615

ENROLLMENT/CHANGE FORM

FOR OFFICE USE ONLY (TO BE COMPLETED BY FUND OFFICE)

GROUP__________ BENEFIT PLAN__________

SUBGROUP__________ EFFECTIVE DATE OF COVERAGE ELECTION__________

EMPLOYMENT STATUS: ☐ACTIVE ☐RETIRED ☐SURVIVING SPOUSE ☐COBRA LABORERS LOCAL #__________

APPROVED BY SIGNATURE (X)__________

CONTRACT CHANGE
☐CANCEL CONTRACT ☐ MOVED ☐ DECEASED ☐ LEFT EMPLOYMENT ☐ TERMINATED ☐ SWITCHED HEALTH PLANS TO:__________

A. MARK PLAN OF CHOICE
☐BLUE CROSS BLUE SHIELD PPO ☐HEALTH ALLIANCE PPO ☐HFN EPO/PPO

B. MEMBER DEPENDENT CHANGE
☐INITIAL ENROLLMENT
☐OPEN ENROLLMENT
☐ADD DEPENDENT(S)
☐NAME CHANGE: FORMER NAME __________
☐ PHYSICIAN CHANGE
☐ ADDRESS/PHONE CHANGE
☐ DELETE DEPENDENT(S)

MARITAL STATUS ☐MARRIED ☐DIVORCED ☐ SINGLE ☐ LEGALLY SEPARATED ☐ WIDOWED

C. MEMBER INFORMATION

NAME (LAST, FIRST, MIDDLE)	MAIDEN NAME OF APPLICANT OR SPOUSE	SEX ☐MALE ☐FEMALE	SOCIAL SECURITY #

MAILING ADDRESS	CITY	STATE	ZIP	COUNTRY

AGE	BIRTH DATE	PRIMARY CARE PHYSICIAN	CURRENT PHYSICIAN ☐YES ☐NO	EMPLOYMENT DATE	HOME TELEPHONE	WORK TELEPHONE

D. FAMILY INFORMATION
List all family members to be covered. Print name as it should appear on I.D. card. Indicate dependent address (if different) in the space below.
Student status information will be required for all family members which exceed age stated for Qualified Dependents in the Certificate.
(Attach documentation of student's full-time status: e.g. class schedule, letter from college admissions office, etc).

NAME (Last, First, Middle)	SOCIAL SECURITY #	RELATION	SEX	BIRTH DATE	FULL TIME STUDENT	PRIMARY PHYSICIAN	EST. PATIENT?	CURRENT
			☐M☐F				Y☐N☐	☐Y☐N
			☐M☐F				Y☐N☐	☐Y☐N
			☐M☐F				Y☐N☐	☐Y☐N
			☐M☐F				Y☐N☐	☐Y☐N

E. OTHER HEALTH INSURANCE INFORMATION *** (THIS SECTION MUST BE COMPLETED)***
On the day your coverage begins will any family members, including those not listed above, be covered by another health benefit 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: ☐ Medical Insurance ☐ Medicaid ☐ Medicare (see below) ☐ Dental Insurance	Insurance Company Name and Phone Number	Policy Number

Policy Coverage Dates: to	Name of Policyholder	Policyholder's Birth date	Family Members Covered

Policyholder's Employer Name	Policyholder's Employer Address	Policyholder's Employer Phone Number

Names of family members covered by Medicare	Medicare I.D. Number	Part A Effec. Date	Part B Effec. Date	Is Medicare eligibility due to: ☐ Kidney Failure ☐ Disability ☐ Age

Is your spouse employed? ☐Yes ☐No If yes, is health insurance offered? ☐Yes ☐No If yes, complete attached form	Name and Address of Spouse's Employer

F. AUTHORIZATION AND RELEASE
(Please read the Authorization and Release which appears below. Please sign your name and date the form in the space provided at the end of this page. Even though your signature appears at the end of this page, you are certifying that you have read and agree to the terms of the entire Authorization and Release).
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 dependents listed on this application.

Date__________ Applicant's Signature__________