# SOUTHERN ILLINOIS LABORERS' & EMPLOYERS HEALTH & WELFARE FUND

5100 Ed Smith Way, Suite A, Marion, IL 62959 618-998-1300 www.silehw.org

PLAN CLASS ELIG EMAIL:

## ENROLLMENT CARD

PLEASE PRINT

| Last Name | First Name | Middle Name | | Phone # | | Local Union # |
|---|---|---|---|---|---|---|
| | | | | Male / Female | Single / Married | / / |

| Mailing Address | City, | State | Zip | Date of Birth |
|---|---|---|---|---|
| | | | | |

Soc Sec # - -

Employer

## DEPENDENTS

| Spouses Name | Soc Sec # | Date of Marriage | | Date of Birth | | |
|---|---|---|---|---|---|---|
| | - - | / / | Covered under other insurance ☐ | / / | | Male / Female |

| Name | Soc Sec # | Date of Birth | | | | |
|---|---|---|---|---|---|---|
| | - - | / / | Covered under other insurance ☐ | Child / Adopted | Step Child | Male / Female |
| | - - | / / | Covered under other insurance ☐ | Child / Adopted | Step Child | Male / Female |
| | - - | / / | Covered under other insurance ☐ | Child / Adopted | Step Child | Male / Female |
| | - - | / / | Covered under other insurance ☐ | Child / Adopted | Step Child | Male / Female |

Are you or your dependents covered under another group insurance plan? Yes ☐ No ☐

Name of Insurance: Policy #

Type of benefits covered:
Medical ☐
Dental ☐

Drug Cards
Yes ☐
No ☐

Address Phone #

## BENEFICIARIES

| Primary | Soc Sec # | Address | Relationship | Phone # |
|---|---|---|---|---|
| | - - | | | |
| Secondary | Soc Sec # | Address | Relationship | Phone # |
| | - - | | | |
| Secondary | Soc Sec # | Address | Relationship | Phone # |

Signature in Ink (Full Name) Date

*NOTE: WE REQUIRE A MARRIAGE CERTIFICATE IF YOU HAVE A DEPENDENT SPOUSE & BIRTH CERTIFICATE FOR DEPENDENT CHILDREN*