Chicago Laborers' Welfare Plan

11465 W. Cermak Road, Westchester, IL 60154 708-562-0200 or 866-906-0200

Extended Coverage for Eligible Dependent Children Enrollment Form

If you have Eligible Dependent children currently not covered under the Plan you have an opportunity to enroll/re-enroll the child(ren) in the Plan. **Coverage will not begin until the first of the month following the month the Fund Office receives your enrollment form.**

Participant Information

Participant Full Name: _____ Participant SSN: _____

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

Home Phone #: _____ Date of Birth: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Eligible Dependent Child(ren) Information

Provide all information for Eligible Dependent Child(ren) to be covered under the Plan.

Child's Full Name (First, MI, Last)	Gender F M	Social Security Number	Date of Birth (mm/dd/yyyy)	Currently Insured? Y N	If currently insured or if employer provided coverage is available anywhere else, please provide the name of insurance, policy #, Group # and telephone #
	☐ ☐		/ /	☐ ☐	
	☐ ☐		/ /	☐ ☐	
	☐ ☐		/ /	☐ ☐	
	☐ ☐		/ /	☐ ☐	

Eligible Dependent Child(ren) Documentation/Proof

You must also enclose a CERTIFIED STATE OR COUNTY duplicate of the birth certificate to add a child. If you send originals, the Fund Office will make copies and return the originals to you. (A certified duplicate is a copy acquired from the state or county in which the birth occurred). Hospital and church records are ***not*** acceptable. All information must be completed and provided or your child will not be enrolled under your group health care coverage until then. **If your child was previously covered under the Plan, you are not required to provide documentation.**

Unless your adult dependents contact the Fund and provide an alternate address, their EOB (Explanation of Benefits) and PHI (Protected Health Information) will be sent to your address.

Participant Authorization

I understand that the information on this form will be used to determine eligibility for coverage for my Eligible Dependent Child(ren) under the Chicago Laborers' Welfare Plan. I hereby certify that the information on this form, to the best of my knowledge and belief, is true, correct, and complete. I also understand that willingly falsifying any of the information on this form is considered fraud and may be cause for termination of coverage as well as imposition of penalties.

Participant Name (print): _____

Participant Signature: _____ Date: _____