Plumbers & Pipefitters Local 553
2 S. Wesley Drive, East Alton, IL 62024

# ENROLLMENT/UPDATE/REINSTATEMENT FORM

Member's Name: _____ Group: P553 H&W Eff. Date: _____
(Last) (First) (Middle Initial)

Address: _____ Date of Birth: _____ M or F: _____

City: _____ State: ____ Zip Code: _____ Member ID# or SS#: _____

Phone Number: _____ e-mail address: _____

Date of Full-Time Employment: _____ Marital Status: Single Married Widowed Divorced Legally Separated

**ELIGIBLE DEPENDENT COVERAGE**: (Spouse and all children under the age of 26)

| Dependent Name | Date of Birth | *Relationship to subscribe | Sex M or F | Dependent SS# | Is Dependent covered under any other group coverage? |
|---|---|---|---|---|---|
| _____ | _____ | Spouse | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | _____ | ☐ Yes ☐ No |
| _____ | _____ | _____ | _____ | _____ | ☐ Yes ☐ No |

*Relationship to subscriber: spouse, natural child, stepchild, foster child, or adopted child

**Is your spouse employed**: ☐ **Yes** ☐ **No**—**IF YES**, is your spouse eligible for insurance coverage through his/her employer: ☐ **Yes** ☐ **No**

**OTHER GROUP COVERAGE INFORMATION:**
If any other group insurance, please provide the name of the subscriber carrying other insurance below and ***provide copy of the insurance card***. Also, if any dependent is 19-26 years, fill out Adult Child Form for each adult dependent.
Subscriber: _____

| Dependent Name | Relationship to Member | Coverage Types and Effective Dates | | | |
|---|---|---|---|---|---|
| _____ | _____ | ☐ Medical Effective Date | ☐ Dental Effective Date | ☐ Vision Effective Date | ☐ Prescription Effective Date |
| _____ | _____ | ☐ Medical Effective Date | ☐ Dental Effective Date | ☐ Vision Effective Date | ☐ Prescription Effective Date |
| _____ | _____ | ☐ Medical Effective Date | ☐ Dental Effective Date | ☐ Vision Effective Date | ☐ Prescription Effective Date |

**BENEFICIARY INFORMATION**: In compliance with the provisions of the Health & Welfare and Pension Trusts, I hereby designate _____ relationship _____ as the person to whom shall be paid any "Benefit" to which I may be entitled at the time of my death. This is in lieu of any former designation made by me.

Witness: Dated this _____ day of _____ 20_____

_____ _____
Witness's Signature Member's Signature

**IMPORTANT**: Is there a court order in place regarding insurance assigning responsibility for health coverage to a specific individual or Parent? ☐**Yes** ☐**No** If, YES, a copy of the order MUST be submitted with your response to this application. An example of such an order is a Qualified Medical Child Support Order (QMCSO) or the part of a divorce decree which addresses those responsible for providing health coverage for this child(ren). Claims will not be considered for benefits until the court order is received.

**I certify that the above information is true, factual, and complete. I understand that falsification of this document may result in a loss of benefits or coverage. If any changes occur, I will promptly notify Local 553.**

_____ _____
Member's Signature Date