SOUTHERN ILLINOIS LABORERS AND EMPLOYERS HEALTH & WELFARE FUND

5100 Ed Smith Way, Suite A, Marion, Illinois 62959 (618) 998-1300

This form must be completed in full for each adult child and submitted to the Fund Office within 30 days. For additional forms, please contact the Fund Office or obtain from the Fund website.

Adult Child (Age 19-26) Enrollment Form

Member Information

Last Name:	First:	MI:	Member ID#:
Street Address:	Home Phone:	Date of Birth:	
City, State, Zip:	Employer:		

Spouse Information

Last Name:	First:	MI:	Social Security #:
Is spouse employed: No Yes	If yes, Employer Name:	Date of Birth:	
Address/Phone Number of Employer:			
Is spouse covered by another health plan? No Yes	Name of Plan:		
Address/Phone Number of Plan:	Group Number:		
Are your dependents covered by this health plan? No Yes	What is the maximum age for dependent coverage under this health plan?		

Please include a copy of the adult child's birth certificate

PLEASE COMPLETE THE SECOND PAGE

Adult Child Information		**Please check here to request an additional medical ID card.**	
Last Name:	First:	MI:	Social Security #:
Phone Number:		Date of Birth:	
Home Address:	City:	State:	Zip:
Are you married? Yes No		Name of Spouse:	
Are you currently employed? Yes No			
If, Yes, please complete this information	Are you eligible for health insurance coverage through your employer? Yes No		
	Employer Name:	Employer Phone:	
	Employer Address:	City/State/Zip:	
If you are married, is your spouse currently employed? Yes No			
If, Yes, please complete this information	Are you eligible for health insurance coverage through your spouse's employer? Yes No		
	Employer Name:	Employer Phone:	
	Employer Address:	City/State/Zip:	

Are you eligible for coverage under any other employer-sponsored health plan besides a group health plan of either of your parents? Yes No

Medical Insurance ☐ YES ☐ NO Drug Card ☐ YES ☐ NO Dental Insurance ☐ YES ☐ NO

If the answer to the above questions is yes, identify the other insurance carrier:_____;

Policy Number_____ Name of Policyholder_____

I certify that:

- The listed Adult Child is eligible for coverage under the terms of the **Southern Illinois Laborers and Employers Health & Welfare Fund**.
- The information provided above is correct to the best of my knowledge, and I authorize the release of any information requested to the **Southern Illinois Laborers and Employers Health & Welfare Fund**.

I understand that the **Southern Illinois Laborers and Employers Health & Welfare Fund** will, from time to time, require updated certification, and that I must notify the Fund Office immediately of any change in the status of my Adult Child (i.e., eligible for health coverage under any other medical insurance or self-insured plan, including that of an employer).

Signature of Member:_____ Date:_____

Signature of Spouse:_____ Date:_____

I certify that:

- I have reviewed the information contained on this form and that it is true and accurate.
- I will notify the above named Member in the event that I become eligible for coverage under any other employer sponsored health insurance or self-insured plan (other than those policies or plans sponsored by my parents' employer(s)).

I understand that the **Southern Illinois Laborers and Employers Health & Welfare Fund** will, from time to time, require updated certification, and that I must notify the Fund Office immediately of any change in my status as an Adult Child (i.e., eligibility for health coverage under any other medical insurance or self-insured plan, including that of an employer).

Signature of Adult Child:_____ Date:_____