ENROLLMENT CARD

MEMBER INFORMATION

LAST NAME	FIRST NAME	MIDDLE	SOC SEC #

MAILING ADDRESS	CITY	STATE	ZIP CODE

BIRTHDATE	GENDER M ☐ F ☐	SINGLE ☐ MARRIED ☐	PHONE #	LOCAL #	EMAIL

DEPENDENTS INFORMATION

SPOUSES NAME	SOC SEC #	BIRTHDATE	MARRIAGE DATE	GENDER M ☐ F ☐	COVERED BY OTHER INSURANCE ☐
PHONE #	EMAIL				

NAME	SOC SEC #	BIRTHDATE		GENDER	
NAME	SOC SEC #	BIRTHDATE	CHILD ☐ STEP CHILD ☐ GUARDIANSHIP ☐	GENDER M ☐ F ☐	COVERED BY OTHER INSURANCE ☐
NAME	SOC SEC #	BIRTHDATE	CHILD ☐ STEP CHILD ☐ GUARDIANSHIP ☐	GENDER M ☐ F ☐	COVERED BY OTHER INSURANCE ☐
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NAME	SOC SEC #	BIRTHDATE	CHILD ☐ STEP CHILD ☐ GUARDIANSHIP ☐	GENDER M ☐ F ☐	COVERED BY OTHER INSURANCE ☐

ADDITIONAL INSURANCE COMPANY	ADDRESS

POLICY #	CONTACT PHONE #	TYPE OF BENEFITS	PHARMACY INSURANCE
		MEDICAL ☐ DENTAL ☐	Yes ☐ No ☐

PRIMARY BENEFICIARY (Individual to receive benefit in the event of your death; cannot be member)

LAST NAME	FIRST	MIDDLE	SOC SEC #

MAILING ADDRESS	PHONE #	BIRTHDATE	RELATIONSHIP

EMAIL	NOTES

SECONDARY BENEFICIARY (Individual to receive benefit in the event of your death; cannot be member)

LAST NAME	FIRST	MIDDLE	SOC SEC #

MAILING ADDRESS	PHONE #	BIRTHDATE	RELATIONSHIP

EMAIL	NOTES

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MEMBER'S SIGNATURE DATE

NOTE: COUNTY CERTIFIED MARIAGE CETIFICATE REQUIRED

COUNTY CERTIFIED BIRTH CERTIFICATES REQUIRED FOR CHILDREN ONLY

ORIGINALS WILL BE RETURNED

RETURN INFORMATION OPTIONS

MAILING ADDRESS

SOUTHERN ILLINOIS LABORERS' & EMPLOYERS' HEALTH & WELFARE FUND

5100 ED SMITH WAY, SUITE A

MARION, IL 62959

FAX: 618-997-9063

EMAIL INFORMATION TO: enrollment@silehw.org

OFFICE # 618-998-1300