

OFFICE OF THE TRUSTEES  
LOCAL UNION NO. 710 HEALTH AND WELFARE FUND  
9000 W. 187<sup>th</sup> Street  
Mokena, IL 60448

Date: \_\_\_\_\_

**2026 ENROLLMENT FORM**

**PLEASE COMPLETE IN ITS ENTIRETY FOR SPOUSE AND EACH DEPENDENT CHILD**

MEMBER NAME: \_\_\_\_\_ MEMBER ID# \_\_\_\_\_ MARITAL STATUS \_\_\_\_\_  
MEMBER ADDRESS: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
MEMBER PHONE NUMBER: \_\_\_\_\_ **MEMBER E-MAIL ADDRESS** \_\_\_\_\_  
NAME OF MEMBER'S EMPLOYER: \_\_\_\_\_

SPOUSE'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_  
\*Name and phone number of SPOUSE's employer \_\_\_\_\_  NOT EMPLOYED

Spouse's Phone Number \_\_\_\_\_ **Spouse's E-Mail Address** \_\_\_\_\_

Does your SPOUSE carry any group insurance?  YES  NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)

Name of Insurance Company \_\_\_\_\_

Has your SPOUSE had any group insurance within the last 12 months?  YES  NO

Start date: \_\_\_\_\_ End Date: \_\_\_\_\_ (If he/she no longer has insurance, please submit a letter of cancellation from his/her previous insurance)

If your SPOUSE has insurance, please check types of coverage on policy:  MEDICAL  DENTAL  VISION  PRESCRIPTIONS

Please check whether single or family coverage:  SINGLE  FAMILY

Is your spouse covered under a high-deductible health plan with a health savings account? \_\_\_\_\_ Yes \_\_\_\_\_ No

If your spouse is covered under a high-deductible health plan, he/she will not be covered under this plan.

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

Child over the age of 18: Phone number \_\_\_\_\_ **E-mail** \_\_\_\_\_

Does your child carry any group insurance?  YES  NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)

Name of Insurance Company \_\_\_\_\_

Has your child had any group insurance within the last 12 months?  YES  NO

Start date: \_\_\_\_\_ End Date: \_\_\_\_\_ (If they no longer have insurance, please submit a letter of cancellation from his/her previous insurance)

If your child has insurance, please check types of coverage on policy:  MEDICAL  DENTAL  VISION  PRESCRIPTIONS

If this adult child is married, does their spouse carry insurance?  NO  MEDICAL  DENTAL  VISION  PRESCRIPTIONS

If yes, please include both sides of the insurance card

Is this adult child a full-time active member of the military or armed forces of any country?  YES  NO

Is your child covered under a high-deductible health plan with a health savings account? \_\_\_\_\_ Yes \_\_\_\_\_ No

If your child is covered under a high-deductible health plan, he/she will not be covered under this plan.

I HEREBY CERTIFY AND AFFIRM THAT THE FOREGOING STATEMENT, INCLUDING ANY ACCOMPANYING DOCUMENTATION, IS TRUE, CORRECT AND COMPLETE. I UNDERSTAND THAT PROVIDING FALSE OR MISLEADING INFORMATION IS A VIOLATION OF APPLICABLE LAW AND MAY RESULT IN THE LOSS OF BENEFITS FOR ME AND FOR MY FAMILY.

\_\_\_\_\_  
**Member Signature**

\_\_\_\_\_  
**Date**

**Para obtener asistencia en Espanol, llame al 773-254-2500**

\*Failure to complete this in its entirety may delay processing of claims for payment.

CHILD'S NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

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Does your child carry any group insurance?  YES  NO (IF YES, PLEASE INCLUDE BOTH SIDES OF THE INSURANCE CARD)

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If yes, please include both sides of the insurance card

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