OFFICE OF THE TRUSTEES
LOCAL UNION NO. 710 HEALTH AND WELFARE FUND
9000 W. 187th 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: _________________________ ARE YOU ELIGIBLE FOR MEDICARE? ____YES ___NO

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
IS YOUR SPOUSE ELIGIBLE FOR MEDICARE? ________YES ____________ NO
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

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.
IS YOUR CHILD ELIGIBLE FOR MEDICARE? ________YES ____________ NO

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: ___________________
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
IS YOUR CHILD ELIGIBLE FOR MEDICARE? _________YES _____________ NO
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.

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
IS YOUR CHILD ELIGIBLE FOR MEDICARE? _________YES _____________ NO
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 ELIGIBLE FOR MEDICARE? ___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.

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
IS YOUR CHILD ELIGIBLE FOR MEDICARE? _________YES _____________ NO

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
ARE YOU ELIGIBLE FOR MEDICARE? ___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.
IS YOUR CHILD ELIGIBLE FOR MEDICARE? _____ YES ___________NO

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
IS YOUR CHILD ELIGIBLE FOR MEDICARE? _________YES _____________ NO
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
ARE YOU ELIGIBLE FOR MEDICARE? ___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.