FOX VALLEY & VICINITY CONSTRUCTION WORKERS WELFARE FUND
MEMBER BENEFITS ENROLLMENT FORM

Effective Date _____ **New Enrollee** ☐ **Open Enrollment** ☐
Local Number _____ **Change in Coverage** **Add** ☐ **Drop** ☐ **Dependent** ☐
Date of Event _____ **Marriage** ☐ **Adoption** ☐ **Birth** ☐ **Loss of Coverage** ☐ **Other** ☐ _____
FOR OFFICE USE ONLY

1. NETWORK (complete entire form in ink)

☒ Blue Cross Blue Shield of IL			

If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, **you must request enrollment within 30 days after marriage, birth, adoption, or placement for adoption** in order to avoid delay in payment of claims.

2. MEMBER INFORMATION (Please Print)

Last Name:	First Name:	Middle:
Address:		Male ☐ Female ☐
City:	State:	Zip Code:	Home Phone: ( )
Social Security Number:	Date of Birth:	Local Number:
☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced		

3. DEPENDENT INFORMATION–

Please attach ***copies*** of marriage license, birth certificates, custody documents, and other dependent insurance information <if applicable>

Name	Birth Date	Gender	Relationship	SSN	Other Insurance
Spouse:					☐ Yes ☐ No
Child 1:					☐ Yes ☐ No
Child 2:					☐ Yes ☐ No
Child 3:					☐ Yes ☐ No
Child 4:					☐ Yes ☐ No

4.SPOUSE EMPLOYMENT AND INSURANCE INFORMATION

Is your spouse employed? ☐ Yes ☐ No	Employer Name & Address:
Is Health Insurance offered? ☐ Yes ☐ No Policy/Group Number:	Name & Address of Insurance Carrier:

5. DEPENDENT INSURANCE INFORMATION Are your children covered by another insurance company? ☐ Yes ☐ No

Name of other Insurance Carrier:	Policy/Group Number:
Address of other Insurance Carrier:	

FAILURE TO DISCLOSE OTHER AVAILABLE HEALTH INSURANCE MAY RESULT IN LOSS OF BENEFITS

6. SIGNATURE

AUTHORIZATION TO PAY PHYSICIAN: I hereby authorize payment directly to the Physician of the Plan of Benefits, if any, otherwise payable to me for services as described but not to exceed the reasonable & customary charges for those services.

I certify the above information is true and correct. I authorize medical providers to furnish Group Administrators with information regarding treatment rendered (including copies of records). I also authorize any union, trust fund, employer or insurance carrier to furnish Group Administrators information regarding benefits to which I or any of my dependents may be entitled.

Member's Signature: _____ **Date:** _____

Return form to Group Administrators, Ltd., 20 N Martingale Rd, Suite 290; Schaumburg, IL 60173
Questions? Call Group Administrators at (800) 323-1683 Fax (855)-978-2331.