Enrollment Form

Mid-America Carpenters Regional Council Health Fund (Fund)
Northern Illinois Region
12 E. Erie St, Chicago, IL 60611
Phone: (312) 787-9455, option 3 | Fax: (312) 951-1515 | Email: submit@macbenefits.org

Dependents must be enrolled within 90 days of a qualifying event to avoid delayed coverage

-SECTION 1: PARTICIPANT INFORMATION

Participant Legal Last Name	Participant Legal First Name	Participant Legal Middle Name

Date of Birth	Gender	Marital Status	Participant Social Security Number
	☐ Male ☐ Female	☐ Never Married ☐ Married ☐ Divorced ☐ Widowed	

Participant Home Address	City	State	Zip

Participant Preferred Phone Number	Is this a Cell?	Opt Out of Important Texts Regarding Coverage?	Email Address
	☐ Yes ☐ No	☐ Yes ☐ No	

If Married, complete this section	Spouse Legal Last Name, First Name, MI		Date of Marriage
	Spouse Social Security Number	Spouse Date of Birth	Spouse Cell Phone

SECTION 2: OTHER INSURANCE INFORMATION

Are you or your dependents insured under any other health plan? ☐ No ☐ Hospital/Medical ☐ Medicare/Tricare	If yes, I have included the **required copies** of my other insurance card(s). ☐ Yes ☐ No

Other Insurance Company Name	Policyholder Name	Relationship to Policyholder

Policy Number	Other Insurance Company Phone Number	Policy Effective Date	Family members covered under Other Insurance Policy ☐ Self ☐ Spouse ☐ All Children ☐ Child: List names:

SECTION 3: DEPENDENT INFORMATION

List all eligible dependents under the age of 26 with Legal name as it appears on Social Security card.

	Dependent Legal Last Name	Dependent Legal First Name	Dependent Legal Middle Name	Dependent DOB	Dependent SSN
1					

Dependent Address - *Check box if same as Participant address* ☐	Relationship to Participant ☐ Natural Child ☐ Adopted Child ☐ Stepchild	Gender ☐ Male ☐ Female	Required docs already submitted? ☐ Yes ☐ No

	Dependent Legal Last Name	Dependent Legal First Name	Dependent Legal Middle Name	Dependent DOB	Dependent SSN
2					

Dependent Address - *Check box if same as Participant address* ☐	Relationship to Participant ☐ Natural Child ☐ Adopted Child ☐ Stepchild	Gender ☐ Male ☐ Female	Required docs already submitted? ☐ Yes ☐ No

	Dependent Legal Last Name	Dependent Legal First Name	Dependent Legal Middle Name	Dependent DOB	Dependent SSN
3					

Dependent Address - *Check box if same as Participant address* ☐	Relationship to Participant ☐ Natural Child ☐ Adopted Child ☐ Stepchild	Gender ☐ Male ☐ Female	Required docs already submitted? ☐ Yes ☐ No

If applicable, additional Dependents should be listed on page 2.

SECTION 3: DEPENDENT INFORMATION CONTINUED

4	Dependent Legal Last Name	Dependent Legal First Name	Dependent Legal Middle Name	Dependent DOB	Dependent SSN
	Dependent Address - *Check box if same as Participant address* ☐	Relationship to Participant ☐ Natural Child ☐ Adopted Child ☐ Stepchild	Gender ☐ Male ☐ Female	Required docs already submitted? ☐ Yes ☐ No	
5	Dependent Legal Last Name	Dependent Legal First Name	Dependent Legal Middle Name	Dependent DOB	Dependent SSN
	Dependent Address - *Check box if same as Participant address* ☐	Relationship to Participant ☐ Natural Child ☐ Adopted Child ☐ Stepchild	Gender ☐ Male ☐ Female	Required docs already submitted? ☐ Yes ☐ No	
6	Dependent Legal Last Name	Dependent Legal First Name	Dependent Legal Middle Name	Dependent DOB	Dependent SSN
	Dependent Address - *Check box if same as Participant address* ☐	Relationship to Participant ☐ Natural Child ☐ Adopted Child ☐ Stepchild	Gender ☐ Male ☐ Female	Required docs already submitted? ☐ Yes ☐ No	

If applicable, additional Dependents should be listed on a separate sheet.

SECTION 4: DOCUMENTATION REQUIREMENTS

*See **Enrollment Form Required Documents** (cover page) for required documents for Spouses and Dependents.*

SECTION 5: PARTICIPANT ACKNOWLEDGEMENT AND SIGNATURE

By providing the information contained in this form, I understand and authorize the Health Fund, its representatives, or its third-party service providers to contact me by phone, email, or mail, for purposes of Health Fund administration and healthcare related activities such as enrollment and medical management. I consent and agree that the Health Fund and its third-party service providers may, from time to time in their sole discretion, make calls or send text messages to me using prerecorded messages or artificial voice or through the use of an automatic telephone dialing system to any phone number provided on this form, including to my cellular phone that could result in charges to me.

I understand it is fraudulent to fill out this form with information I know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse the Mid-America Carpenters Regional Council Health Fund for any money it was induced to pay as a result of the information I provided. Receipt or completion of this form is not a guarantee of eligibility.

X

Participant Signature **Date**

Submit completed Enrollment Form with copies of all required documents:

- **MAIL**: 12 E. Erie, St., Chicago, IL 60611
- **DROP-OFF:** 12 E. Erie, St., Chicago, IL 60611 *or* 4979 Indiana Ave, Lisle, IL 60532
- **Email**: submit@macbenefits.org
- **Fax**: (312) 951-1515