ST. LOUIS GRAPHIC ARTS JOINT HEALTH & WELFARE FUND
14323 South Outer Forty Rd, Suite 106 South
Chesterfield, Missouri 63017
(314) 878-1579 (314) 275-2640 (fax) www.slgahw.org

ENROLLMENT FORM

Section A - Member Information - Please print clearly in ink

Last Name	First Name	Middle Name	ID Number
Date of Birth	Gender ( ) Male ( ) Female	Marital Status ( ) single ( ) divorced ( ) widowed ( ) married, date: ________________	Social Security Number
Home Address		City and State	Zip
Home Phone	Cell Phone		E-mail

Section B - Election of Coverage - I elect the following coverage:

( ) Individual (Employee only coverage)

( ) **Employee with Child(ren) Only** (no spouse) - Proceed to Section D

( ) Employee with Spouse Only (no children) - Proceed to Section C

( ) **Employee with Spouse and Child(ren)** - Proceed to Section C

NOTE: UNLESS YOU HAVE ALREADY PROVIDED DOCUMENTATION TO THE FUND OFFICE, YOU WILL NEED TO PROVIDE A COPY OF YOUR MARRIAGE CERTIFICATE FOR COVERAGE TO BE EFFECTIVE

Section C - Spouse Information (if applicable) - Please print clearly in ink

Last Name	First Name	Middle Name	Social Security Number
Home Address (if different than member)		City and State	Zip
Date of Birth	Gender ( ) Male ( ) Female	Do you have other insurance coverage AVAILABLE? ( ) Yes ( ) No If you answered YES, you are not eligible to be covered under the plan.	
Home Phone	Cell Phone		E-mail

If you elect **Employee with spouse only coverage** or **Employee with spouse and child(ren) coverage**, review each of the following statements and indicate your understanding and agreement of each statement by initialing in the box.

☐ I understand that my spouse is NOT eligible for coverage in this Plan if he/she has coverage **available** through his/her employer's plan whether or not my spouse has actually enrolled in the coverage available through his/her employer.

☐ I represent that my spouse does NOT have coverage available through his/her employer's plan and is eligible for coverage in this Plan as my spouse.

☐ I understand that it is my responsibility to inform the Fund Office if there is a change in my spouse's employment status or in my spouse's eligibility for coverage through his/her employment (for example the end of a probationary period or a change to full-time status).

Complete this section if you elected coverage that includes your child(ren)

List all your eligible children under age 26 (if you are unsure if a child is eligible see section 1.1.4 of the SPD)

NOTE: UNLESS YOU HAVE ALREADY PROVIDED DOCUMENTATION TO THE FUND OFFICE, YOU WILL NEED TO PROVIDE A COPY OF THE CHILD'S BIRTH CERTIFICATE AND/OR A COPY OF THE LEGAL ORDER TO PROVIDE MEDICAL COVERAGE

Section D - Dependent #1 Information (if applicable) - Please print clearly in ink

Last Name	First Name	Middle Name	Date of Birth	Social Security Number

Gender	Insurance	Other insurance details
Gender ( ) Male ( ) Female	Is the dependent covered through other insurance? ( ) yes ( ) no If yes, coverage type: ( ) medical ( ) dental ( ) vision	Name of Plan: ____________ Phone number of Plan: ____________ Policy # ____________ Effective date of other insurance coverage: ____________ Termination date of other insurance coverage: ____________

Home Address (if different than member)	City, State & Zip	Marital Status
		Marital Status ( ) single ( ) divorced ( ) widowed ( ) married, date: ____________

Home Phone	Cell Phone	E-mail	Your relationship to child:
			( ) natural child ( ) adopted child ( ) step child ( ) Other ________

Dependent #2 Information (if applicable) - Please print clearly in ink

Last Name	First Name	Middle Name	Date of Birth	Social Security Number

Home Address (if different than member)	City, State & Zip	Marital Status
		Marital Status ( ) single ( ) divorced ( ) widowed ( ) married, date: ____________

Gender	Insurance	Other insurance details
Gender ( ) Male ( ) Female	Is the dependent covered through other insurance? ( ) yes ( ) no If yes, coverage type: ( ) medical ( ) dental ( ) vision	Name of Plan: ____________ Phone number of Plan: ____________ Policy # ____________ Effective date of other insurance coverage: ____________ Termination date of other insurance coverage: ____________

Home Phone	Cell Phone	E-mail	Your relationship to child:
			( ) natural child ( ) adopted child ( ) step child ( ) Other ________

- I authorize my employer to withhold my share of the cost of coverage from my wages.
- I understand that coverage of my dependents is subject to the eligibility rules of the Plan.
- I understand that if I enroll in Individual only coverage, I will not be able to add any dependents until the next open enrollment unless there is a special enrollment event.
- I understand that it is my responsibility to immediately notify the Fund Office of any change in the information on this form. I understand that the Fund can verify the information relating to eligibility at any time.
- I understand that providing incorrect or false information and not timely updating information can result in a denial of benefits or a termination of eligibility and that if claims are paid based on false information, I could be responsible for the entire amount due to the provider.

IMPORTANT: If this enrollment form is not completed and returned to the Fund Office by November 1, 2016, the Fund will enroll you in individual coverage and terminate all dependents as of January 1, 2017.

______________________________________ ______________________
(Signature) (Date)

____
(Print Name)

NOTE: UNLESS YOU HAVE ALREADY PROVIDED DOCUMENTATION TO THE FUND OFFICE, YOU WILL NEED TO PROVIDE A COPY OF THE CHILD'S BIRTH CERTIFICATE AND/OR A COPY OF THE LEGAL ORDER TO PROVIDE MEDICAL COVERAGE

Dependent #3 Information (if applicable) - Please print clearly in ink

Last Name	First Name	Middle Name	Date of Birth	Social Security Number

Gender	Is the dependent covered through other insurance?	
( ) Male ( ) Female	insurance? ( ) yes ( ) no If yes, coverage type: ( ) medical ( ) dental ( ) vision	Name of Plan: ___ Phone number of Plan: ___ Policy # ___ Effective date of other insurance coverage: ___ Termination date of other insurance coverage: ___

Home Address (if different than member)	City, State & Zip	Marital Status ( ) single ( ) divorced ( ) widowed ( ) married, date: ___

Home Phone	Cell Phone	E-mail	Your relationship to child: ( ) natural child ( ) adopted child ( ) step child ( ) Other ___

Dependent #4 Information (if applicable) - Please print clearly in ink

Last Name	First Name	Middle Name	Date of Birth	Social Security Number

Home Address (if different than member)	City, State & Zip	Marital Status ( ) single ( ) divorced ( ) widowed ( ) married, date: ___

Gender	Is the dependent covered through other insurance?	
( ) Male ( ) Female	insurance? ( ) yes ( ) no If yes, coverage type: ( ) medical ( ) dental ( ) vision	Name of Plan: ___ Phone number of Plan: ___ Policy # ___ Effective date of other insurance coverage: ___ Termination date of other insurance coverage: ___

Home Phone	Cell Phone	E-mail	Your relationship to child: ( ) natural child ( ) adopted child ( ) step child ( ) Other ___

Dependent #5 Information (if applicable) - Please print clearly in ink

Last Name	First Name	Middle Name	Date of Birth	Social Security Number

Home Address (if different than member)	City, State & Zip	Marital Status ( ) single ( ) divorced ( ) widowed ( ) married, date: ___

Gender	Is the dependent covered through other insurance?	
( ) Male ( ) Female	insurance? ( ) yes ( ) no If yes, coverage type: ( ) medical ( ) dental ( ) vision	Name of Plan: ___ Phone number of Plan: ___ Policy # ___ Effective date of other insurance coverage: ___ Termination date of other insurance coverage: ___

Home Phone	Cell Phone	E-mail	Your relationship to child: ( ) natural child ( ) adopted child ( ) step child ( ) Other ___

Dependent #6 Information (if applicable) - Please print clearly in ink

Last Name	First Name	Middle Name	Date of Birth	Social Security Number

Home Address (if different than member)	City, State & Zip	Marital Status ( ) single ( ) divorced ( ) widowed ( ) married, date: ___

Gender	Is the dependent covered through other insurance?	
( ) Male ( ) Female	insurance? ( ) yes ( ) no If yes, coverage type: ( ) medical ( ) dental ( ) vision	Name of Plan: ___ Phone number of Plan: ___ Policy # ___ Effective date of other insurance coverage: ___ Termination date of other insurance coverage: ___

Home Phone	Cell Phone	E-mail	Your relationship to child: ( ) natural child ( ) adopted child ( ) step child ( ) Other ___