

Chicago Laborers' Welfare Plan

11465 W. Cermak Road, Westchester, IL 60154

708-562-0200 or 866-906-0200

ENROLLMENT FOR INDIVIDUALS WHO REACHED LIFETIME LIMIT

If you or your dependents have lost coverage because you reached the Plan's current lifetime limit, you have a Special Enrollment opportunity to enroll/re-enroll yourself or your dependents in the Plan as long as you or your dependents continue to meet the eligibility requirements of the Plan. **You must send this completed form and any required documentation to the Fund Office.**

Participant Information

Participant Full Name: _____ Participant SSN: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Date of Birth: _____ Marital Status: Single Married Divorced Widowed

I am adding the following person(s) to my health coverage for this special enrollment.
Check all that apply.

- Myself.** I reached the lifetime limit and would like to reinstate my health coverage. [Complete Section A below and sign Section D on the back.]
- Spouse.** My spouse reached the lifetime limit and I would like to reinstate my spouse's health coverage. [Complete Sections A and B below and sign Section D on the back.]
- Child.** My child reached the lifetime limit and I would like to reinstate my child's health coverage. [Complete Sections A and C and sign Section D on the back.]

Section A: Employee Information (must be completed) Please print all sections.

NAME	_____
SSN#	_____
ADDRESS	_____
CITY, STATE, ZIP	_____
PHONE NUMBER	() -
DATE OF BIRTH	_____/_____/_____

Section B: Spouse Information Please print all sections.

MARRIED NAME	_____
MAIDEN NAME	_____
SSN#	_____
DATE OF BIRTH	_____/_____/_____
MARRIAGE DATE	_____/_____/_____

- I am enclosing a **Certified State or County Copy** of my marriage certificate.

Section C: Dependent Information Please print all sections.

1. CHILD'S FULL NAME

SSN#

DATE OF BIRTH

I am enclosing a **Certified State or County Copy** of the birth certificate.

If applicable, I am enclosing a Voluntary Acknowledgement of Paternity or Qualified Medical Child Support Order.

2. CHILD'S FULL NAME

SSN#

DATE OF BIRTH

I am enclosing a **Certified State or County Copy** of the birth certificate.

If applicable, I am enclosing a Voluntary Acknowledgement of Paternity or Qualified Medical Child Support Order.

Section D: Participant Authorization

I hereby certify that the information on this form, to the best of my knowledge and belief, is true, correct, and complete. I also understand that willingly falsifying any of the information on this form is considered fraud and may be cause for termination of coverage as well as imposition of penalties.

Participant Name (print): _____

Participant Signature: _____ Date: _____