Enrollment Form

☐ *This is an STLKC Office Employee Plan*

Mid-America Carpenters Regional Council Health Fund (Fund)
St. Louis-Kansas City Southern Region
1419 Hampton Avenue, St. Louis, MO 63139
Phone: (314) 644-4802, option 1 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org

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

SECTION 1: PARTICIPANT INFORMATION

STLKC OE Plan Only: Employer Name _____

Participant Legal Last Name		Participant Legal First Name	Participant Legal Middle Name
Date of Birth	Gender ☐ Male ☐ Female	Marital Status ☐ Never Married ☐ Married ☐ Divorced ☐ Widowed	Participant Social Security Number
Participant Home Address		City	State / Zip
Participant Preferred Phone Number	Is this a Cell? ☐ Yes ☐ No	Opt In to Important Texts Regarding Coverage? ☐ Yes ☐ No	Email Address
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 dependent children insured under any other health plan? ☐ No ☐ Hospital/Medical ☐ Prescription ☐ Dental ☐ Vision	If yes, I have included the **required copies** of my other insurance card(s). ☐ ***STLKC Only:*** *Do not list spouse information here. See* ***Spousal Coverage Verification Form****.*	
Other Insurance Company Name	Policyholder Name	Relationship to Policyholder
Policy Number	Other Insurance Company Phone Number	Family members covered under Other Insurance Policy ☐ Self ☐ Spouse (Verification Form Required) ☐ 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.

1	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? ☐ Yes ☐ No
2	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? ☐ Yes ☐ No
3	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? ☐ 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? ☐ 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? ☐ 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? ☐ 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 moil, 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 you 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:

- **Upload** securely to the Member Portal: **laborfunds.org/member-portal**
- By **mail** to the address at the top of this form, Attn: Participant Services
- By **fax** to the fax number at the top of this form