



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 Out of Important Texts Regarding Coverage? ☐ Yes		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: <u>Do not</u> list spouse information here. See <u>Spousal Coverage Verification Form</u>.	
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
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
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

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 - <i>Check box if same as Participant address</i> ☐			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 - <i>Check box if same as Participant address</i> ☐			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 - <i>Check box if same as Participant address</i> ☐			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	
<i>See Enrollment Form Required Documents (cover page) for required documents for Spouses and Dependents.</i>	

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>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.</i>	

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