

Pipe Fitters' Welfare Fund, Local 597

45 North Ogden Avenue, Chicago, Illinois 60607
 Phone 312.633.0597 Fax 312.829.7787 www.pf597.org

ADULT CHILD ENROLLMENT FORM (Ages 18 through 25)

| | | | | | |
|---------------------------|------------------------|------|---------------------|--------------|-------|
| Member Information | | | | | |
| Member's Name | _____ | | | Phone Number | _____ |
| Address | First | Last | | | |
| | Street | City | State | Zip | |
| | Social Security Number | | or U.A. Card Number | | |

ADULT CHILD INFORMATION

| | | | | | |
|--------------|------------------------|------|------------|--------------|-------|
| Child's Name | _____ | | | Phone Number | _____ |
| Address | First | Last | | | |
| | Street | City | State | Zip | |
| | Social Security Number | | Birth Date | | |

Marital Status: Single Married

If married, Name of Child's Spouse: _____

Employment

If your Adult Child or their Spouse is employed please complete below:

Adult Child Employer's Name and Phone Number _____ Spouse's Employer's Name and Phone Number _____

Is your Adult Child or their spouse if applicable covered by any other plan (including group insurance, prescription drug, dental, vision, student or sports policies, or Medicare?)

Yes No

If yes, complete next section below

TELL US ABOUT YOUR OTHER INSURANCE

| Type of Coverage | Insurance Company Name and Phone Number | Policy Holders Name and I.D. Number | Effective Date | Who is Covered |
|--|---|-------------------------------------|----------------|---|
| Medical <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children |
| Prescription Drug <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children |
| Dental <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children |
| Vision <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children |
| Medicare <input type="checkbox"/> Yes <input type="checkbox"/> No | | | | <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Children |

I certify that all information provided on this form is correct to the best of my knowledge and authorize release of any information requested with respect to this enrollment form. I understand that Pipe Fitters' Welfare Fund Local 597, at its sole discretion, may rescind my coverage at any time on the basis of any untrue, inaccurate or incomplete answer to any question on this enrollment form, or any misrepresentation, omission or concealment on this enrollment form, whether intentional or otherwise. I also understand that if this information changes, it is my responsibility to notify the Fund Office immediately.

Member's Signature _____ Date _____

Adult Child's Signature _____ Date _____