CHAUFFEURS, TEAMSTERS & HELPERS
LOCAL 301, HEALTH & WELFARE FUND
Michael T. Haffner, Chairman
36990 NORTH GREENBAY ROAD
WAUKEGAN, IL 60087
(847) 623-3915

2025 ENROLLMENT FORM

FORM MUST BE COMPLETED EVERY YEAR

The following is your Teamsters Local 301 Health and Welfare Fund Enrollment Form for plan year beginning January 1, 2025.

THIS FORM MUST BE COMPLETED IN ITS ENTIRETY AND RETURNED TO THE FUND OFFICE WITHIN 30 DAYS OF YOUR EFFECTIVE DATE OF COVERAGE FOR THE PLAN YEAR BEGINNING JANUARY 1, 2025.

Please complete the information for yourself and your dependents AND answer the questions regarding any all other coverage information. Forms with any missing information will be returned resulting in delayed enrollment and no claims will be processed until the missing information is received.

If you are adding a dependent, please make sure to include a copy of your marriage license for spouse or birth certificate for dependents.

PLEASE NOTE: The information provided is being sent to the IRS to verify if you had coverage as required in the Affordable Care Act. Therefore, the information provided must match the Social Security (SS) Card for you and your dependents!! The information is also used to meet reporting requirements of Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007. Please make sure the NAME (first and last) AND SS# on this form is exactly as it appears on the SS Card. If your SS Card is different please make changes on this form. We will submit the information exactly as you have provided it.

This form must be completed and returned for dependents to be enrolled for coverage for Plan Year 2025. Failure to return the form by the due date will result in a delay of coverage for your dependents. Forms must be returned within 30 days of the effective date of coverage to avoid any further delay of coverage for your dependents.

Please read this form carefully, fill it out and verify the information completely and sign it. Return the form with the applicable marriage and birth certificates. A self-addressed, return envelope has been provided for your convenience. Return the enrollment documents as soon as possible to prevent any delay. Should you need additional forms, please call the Claims Office at 847-623-3915.

This form does not guarantee coverage. You must meet the eligibility rules of the Plan for coverage.

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A. Employee Information

Please complete the form below, print, and mail to address above.

Name:

Home /Cell
Phone Number(s):

SSN#:

Date of Birth:

Employer Name:

Marital Status: ☐ Married ☐ Divorced ☐ Legally Separated ☐ Single/Never Married ☐ Widowed

B. Dependent Information.

Spouse	Name and Contact Info.	SS#	Date of Birth	for office use
☐ Enroll	Cell Phone:			
Please list Spouse's Employer and Address:				

Please Note: All New Enrollments must include Marriage Certificate

Children	Name	SS#	Date of Birth	for office use
☐ Enroll				
☐ Enroll				
☐ Enroll				
☐ Enroll				
☐ Enroll				
☐ Enroll				
☐ Enroll				

Please Note: All New Enrollments must include Birth Certificate

DON'T FORGET!
SIGNATURES REQUIRED ON SECTION D (last page)

C. OTHER COVERAGE INFORMATION – COORDINATION OF BENEFITS (COB)

Will you or any of your dependents have ANY other coverage in effect for 2025?

Medical: ☐ YES ☐ NO
Dental: ☐ YES ☐ NO
Vision: ☐ YES ☐ NO
Medicare: ☐ YES ☐ NO

If you answered YES to any of the above, please provide the information below.	If your answer is NO for all of the above, please go to the next page.

MEDICAL	
Name of Medical Plan:	
Name of Policyholder:	
Please list ALL family members covered by this plan:	
DENTAL	
Name of Dental Plan:	
Name of Policyholder:	
Please list ALL family members covered by this plan:	
VISION	
Name of Vision Plan:	
Name of Policyholder:	
Please list ALL family members covered by this plan:	
MEDICARE	
Please List ALL family members covered by Medicare:	

If more than one plan, divide the boxes or use the space below to explain.

D. Statement of Understanding – Authorization and Consent (Must be signed by Participant and Spouse)

By signing this application, I represent that all my answers are complete and accurate, and that I understand and agree to the following conditions:

- No person, Business Associate, employee of the Chauffeurs, Teamsters and Helpers Local No. 301 Health and Welfare Fund (the "Fund"), or my employer can change any part of this claim form or waive the requirement that I answer all questions completely and accurately.
- The Chauffeurs, Teamsters and Helpers Local No. 301 Health and Welfare Fund may, at its discretion, request supplemental information from me, any family member listed on this application or any health care provider.
- On behalf of myself and all enrolled family members, I understand if the Chauffeurs, Teamsters and Helpers Local No. 301 Health and Welfare Fund or its Business Associates discovers any intentional misrepresentation, omission or concealment of fact that was or would have been material to the provision of benefits or payment of any claim, the Chauffeurs, Teamsters and Helpers Local No. 301 Health and Welfare Fund may take action against me to recover such payment including but not limited to offsetting future claims.
- I acknowledge and understand the Chauffeurs, Teamsters and Helpers Local No. 301 Health and Welfare Fund and its Business Associates may request or disclose health information about me or my dependents (persons who are listed for benefits coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law. For more information about such uses and disclosures, including uses and disclosures required by law, please refer to the Chauffeurs, Teamsters and Helpers Local No. 301 Health and Welfare Fund Notice of Privacy Practices that is available at 36990 North Green Bay Road, Waukegan, Illinois 60087.
- I understand that my signature on this form will also serve as authorization to any doctor, hospital, clinic or health care provider, insurance (or reinsuring) company, consumer reporting agency, insured's agent, family member, employers or any other person or firm having, (i) information as to diagnosis, treatment and prognosis of the claimant's physical or mental condition, or (ii) any other information needed to determine claim benefits with respect to the claimant, to give to the Chauffeurs, Teamsters and Helpers Local No. 301 Health and Welfare Fund ("The Fund"), its employees and agents, insured's agent or any other consumer reporting agency all such health information. This includes (but is not limited to): driving records, psychiatric, drug and alcohol abuse history and treatment information. I understand the information will be included as part of the proof of claim and will be used by "The Fund" for the purposes of payment and health care operations as outlined in "The Fund's" Notice of Privacy Practices which I understand I have a right to review prior to signing this consent.
- I understand that if the Notice of Privacy Practices is revised, I will be provided with a copy of the amended document. I further understand that my health information will be used to determine claim benefits with respect to the claimant. It will not be released to anyone else except as provided for in the Notice of Privacy Practices, including a) reinsuring companies; b) fraud or overinsurance detection bureaus; c) anyone performing business, medical or legal functions with respect to the claim; d) as may be required by law; e) as I may further authorize or consent to. I further understand that my signature on this form serves as an authorization to the Fund to disclose or release health information to the Teamsters Local No. 301 Pension Fund
- "I understand that I may request restrictions on how my health information is used for payment and health care operations and that "The Fund" may deny or grant the request and that if granted, "The Fund" will be bound by that restriction.
- I understand that this authorization may be revoked by written notice to "The Fund". This will not apply to information already released. If not revoked, this authorization will be valid during the term of coverage of the claimant up to one year from the date that it was signed. I may request a copy of this authorization / consent. I also agree that a photocopy shall be as valid as the original
.
- This signature also verifies that I am legally married to the spouse listed above. Any misstatement of marital status or legal dependents can be considered fraudulent and subject to legal action.
- I affirm that I have reviewed all answers given on this claim form and, regardless of whether another person has filled out the answers for me; I verify that the answers are true and complete

Signature of Member	**Signature of Spouse**	Date
Signature of Personal Representative	Relationship to Claimant or Basis of Authority	Date

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