



**CENTRAL STATES  
SOUTHEAST AND  
SOUTHWEST AREAS  
HEALTH AND WELFARE AND PENSION FUNDS**

**EMPLOYEE TRUSTEES**  
RAY CASH  
JERRY YOUNGER  
GEORGE J. WESTLEY  
CHARLES A. WHOBREY  
FRED GEGARE

**EMPLOYER TRUSTEES**  
HOWARD McDOUGALL  
ARTHUR H. BUNTE, JR.  
TOM J. VENTURA  
DANIELJ. BRUTTO  
GARY F. CALDWELL

**EXECUTIVE DIRECTOR**  
THOMAS C. NYHAN

**CHANGE IN ENROLLMENT INFORMATION**

Dear Participant:

Below is a "Change In Enrollment Form". Please Complete the necessary sections, sign, date, and return this form to the Funds as soon as possible.

**INSTRUCTIONS**

1. All information must be printed legibly in ink.
2. It is very important that we have your legal first name.  
(no nicknames please)
3. Please check the appropriate box (es).

- Social Security Number Change – please indicate incorrect  
Social Security Number here: \_\_\_\_\_
- Address Change
- Change in Marital Status
- Change or Add Eligible dependents. Further documents will be required in cases of Divorce, Step-Children or Adoptions. You may call our Toll-Free Department at 1-800-323-5000 to check on specific documents we may require.

Members Social Security Number						Birth Date MM / DD / YY						Sex		
												<input type="checkbox"/> M	<input type="checkbox"/> F	
Legal Last Name						Legal First Name						MI		
Street Address											Area + Telephone Number			
City						State		Zip Code						
Local Union #														

Married \_\_\_\_\_ Single \_\_\_\_\_ Spouse's Last Name: \_\_\_\_\_

Spouse First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Spouse Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_

Is your Spouse employed?: \_\_\_\_\_ Yes \_\_\_\_\_ No

Does Spouse have health insurance through employer?: \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, does it include: \_\_\_\_\_ Vision \_\_\_\_\_ Dental \_\_\_\_\_ RX \_\_\_\_\_ Medical

Effective Date of Coverage: \_\_\_\_/\_\_\_\_/\_\_\_\_

Spouse's Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Marriage Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Name of Spouse's Employer: \_\_\_\_\_

Does Spouse's health insurance include coverage for dependents? \_\_\_\_\_ Yes \_\_\_\_\_ No

Name of Insurance Company: \_\_\_\_\_

Address: \_\_\_\_\_

GROUP NUMBER	POLICY NUMBER

FAMILY ENROLLMENT DATA – please list all eligible dependents (Full Name)

Last Name	First Name	MI	Birthdate	Sex	Legal Relationship
_____	_____	_____	____/____/____	_____	_____
_____	_____	_____	____/____/____	_____	_____
_____	_____	_____	____/____/____	_____	_____
_____	_____	_____	____/____/____	_____	_____
_____	_____	_____	____/____/____	_____	_____

NOTE:

1. Further documentation may be required by Central States to verify the eligibility of your dependents.
2. If you want to change your Life Insurance Beneficiary, please request a Change of Beneficiary card from your Local Union or by calling the Fund toll-free at 1-800-323-5000.
3. You may want to keep a copy for your files.
4. If you have any questions on how to complete this form, call 1-800-323-5000

**MAIL THIS FORM TO: Central States Health and Welfare Fund  
P.O. Box 5112 Des Plaines, IL 60017-5112**

To validate this form, your signature and date signed is necessary:

\_\_\_\_\_  
Participant's signature

\_\_\_\_\_  
Date