TEAMCARE ENROLLMENT FORM

We are pleased to have you as a participant of TeamCare, a Central States Health Plan. It is very important for you to complete this Enrollment Form so that future health and welfare claims are not delayed for you and your dependents. Please complete, sign and return this form to TeamCare as soon as possible.

*** See insert for enrollment requirements ***

SECTION 1	EMPLOYEE INFORMATION				
NAME OF EMPLOYER		LOCAL UNION		DATE OF HIRE	
SOCIAL SECURITY NO. (required by Federal law)		BIRTH DATE			
LAST NAME		FIRST NAME		MIDDLE INITIAL	
ADDRESS					
CITY		STATE		ZIP CODE	
PHONE NUMBER		E-MAIL ADDRESS			
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED				GENDER:	☐ MALE ☐ FEMALE

☐ CHECK HERE IF THIS IS A NEW ADDRESS. ☐ CHECK HERE IF ADDITIONAL MEDICAL CARDS ARE NEEDED.

SECTION 2	SPOUSE INFORMATION				
SPOUSE'S SOC SEC NO. (required by Federal law)		BIRTH DATE		MARRIAGE DATE	
LAST NAME		FIRST NAME, MIDDLE INITIAL		GENDER:	☐ MALE ☐ FEMALE
SPOUSE'S EMPLOYER		PHONE			
DOES YOUR SPOUSE HAVE INSURANCE THROUGH HIS/HER EMPLOYER? ☐ YES ☐ NO ☐ NOT EMPLOYED					
NAME OF INSURANCE			PHONE		
GROUP POLICY NUMBER			EFFECTIVE DATE		
CHECK ALL THE COVERAGES PROVIDED BY SPOUSE'S INSURANCE: ☐ MEDICAL ☐ RX ☐ DENTAL ☐ VISION					
DOES YOUR SPOUSE'S INSURANCE PROVIDE COVERAGE FOR CHILDREN? ☐ YES ☐ NO					

IMPORTANT: Spouse information is **required** for Coordination of Benefits purposes.

SECTION 3A	CHILD INFORMATION				
LAST NAME	**FIRST NAME**	**MI**	**BIRTH DATE**	**GENDER** Check One	**RELATIONSHIP TO EMPLOYEE**
Please note that the Adult Child Enrollment (section 3B) on the back page must also be completed for any child from age 19 through age 25.					
				☐ M ☐ F	
				☐ M ☐ F	
				☐ M ☐ F	
				☐ M ☐ F	

(List additional children on a separate sheet)

Please note that TeamCare may require additional documentation before claims can be processed. If you have any questions regarding the enrollment process, please call our Participant Services Department at 1-800-323-5000.

Please mail to: TeamCare
A Central States Health Plan
PO Box 5112
Des Plaines, IL 60017-5112

Or fax to: (847) 518-9779

I certify the accuracy of this information and understand that I must inform TeamCare of any changes.

PARTICIPANT SIGNATURE _____ **DATE** _____

ALSCO Employees

CENTRAL STATES HEALTH & WELFARE FUND ENROLLMENT FORM

As part of your benefits package with your employer, you must elect your level of dependent coverage. There are two choices: **Member Only** or **Family** coverage. It is important that you understand that your election is binding and can only be changed during the Open Enrollment period, or as indicated on the attached **ENROLLMENT NOTICE FOR MULTI-TIERED PLANS** document.

Please select your level of dependent coverage:

☐ **Member Only Coverage** (Complete Section 1)

☐ **Family Coverage** (Complete Sections 1, 2 & 3)

*** See insert for enrollment requirements ***

SECTION 1 EMPLOYEE INFORMATION

NAME OF EMPLOYER		LOCAL UNION		DATE OF HIRE	
SOCIAL SECURITY NO. (required by Federal law)		BIRTH DATE			
LAST NAME		FIRST NAME		MIDDLE INITIAL	
ADDRESS					
CITY		STATE		ZIP CODE	
PHONE NUMBER		E-MAIL ADDRESS			
MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED				GENDER:	☐ MALE ☐ FEMALE

☐ CHECK HERE IF THIS IS A NEW ADDRESS.

☐ CHECK HERE IF ADDITIONAL MEDICAL CARDS ARE NEEDED.

SECTION 2 SPOUSE INFORMATION

SPOUSE'S SOC SEC NO. (required by Federal law)		BIRTH DATE		MARRIAGE DATE	
LAST NAME		FIRST NAME, MIDDLE INITIAL		GENDER:	☐ MALE ☐ FEMALE
SPOUSE'S EMPLOYER		PHONE			
DOES YOUR SPOUSE HAVE INSURANCE THROUGH HIS/HER EMPLOYER? ☐ YES ☐ NO ☐ NOT EMPLOYED					
NAME OF INSURANCE				PHONE	
GROUP POLICY NUMBER				EFFECTIVE DATE	
CHECK ALL THE COVERAGES PROVIDED BY SPOUSE'S INSURANCE: ☐ MEDICAL ☐ RX ☐ DENTAL ☐ VISION					
DOES YOUR SPOUSE'S INSURANCE PROVIDE COVERAGE FOR CHILDREN? ☐ YES ☐ NO					

IMPORTANT: Spouse information is required for Coordination of Benefits purposes even if spouse coverage is not elected.

SECTION 3A CHILD INFORMATION

LAST NAME	FIRST NAME	MI	BIRTH DATE	GENDER Check One	RELATIONSHIP TO EMPLOYEE
Please note that the Adult Child Enrollment (section 3B) on the back page must also be completed for any child from age 19 through age 25.					
				☐ M ☐ F	
				☐ M ☐ F	
				☐ M ☐ F	
				☐ M ☐ F	
				☐ M ☐ F	

(List additional children on a separate sheet)

I have read the **ENROLLMENT NOTICE FOR MULTI-TIERED PLANS** and understand that changes in my coverage can only be made in accordance with those guidelines. I also certify the accuracy of the information I provided and understand that I must inform the Health and Welfare Fund of any changes.

MEMBER SIGNATURE _____ **DATE** _____

FOR OFFICE USE ONLY
Accounts Receivable Update: