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 * **EMPLOYEE INFORMATION** SECTION 1 DATE OF LOCAL UNION NAME OF EMPLOYER HIRE SOCIAL SECURITY NO. **BIRTH DATE** (required by Federal law) MIDDLE LAST NAME FIRST NAME INITIAL ADDRESS ZIP CODE CITY STATE E-MAIL ADDRESS PHONE NUMBER ☐ MALE GENDER: MARITAL STATUS: ☐ SINGLE ■ MARRIED □ DIVORCED □ WIDOWED ☐ FEMALE ☐ CHECK HERE IF THIS IS A NEW ADDRESS. ☐ CHECK HERE IF ADDITIONAL MEDICAL CARDS ARE NEEDED. SPOUSE INFORMATION SECTION 2 MARRIAGE SPOUSE'S SOC SEC NO. BIRTH DATE DATE (required by Federal law) MALE FIRST NAME. GENDER: LAST NAME FEMALE MIDDLE INITIAL SPOUSE'S EMPLOYER ■ NOT EMPLOYED DOES YOUR SPOUSE HAVE INSURANCE THROUGH HIS/HER EMPLOYER? ☐ YES □ NO PHONE NAME OF INSURANCE **EFFECTIVE DATE GROUP POLICY NUMBER** ☐ MEDIÇAL ☐ DENTAL □ VISION CHECK ALL THE COVERAGES PROVIDED BY SPOUSE'S INSURANCE: □ RX DOES YOUR SPOUSE'S INSURANCE PROVIDE COVERAGE FOR ☐ YES □ NO CHILDREN? IMPORTANT: Spouse information is required for Coordination of Benefits purposes. CHILD INFORMATION SECTION 3A RELATIONSHIP **GENDER BIRTH DATE** LAST NAME **FIRST NAME** MI Check One 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. □Æ ΠМ \square M DF \square M \Box F □м □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. Or fax to: (847) 518-9779 Please mail to: **TeamCare** A Central States Health Plan PO Box 5112 Des Plaines, IL 60017-5112 I certify the accuracy of this information and understand that I must inform TeamCare of any changes. DATE PARTICIPANT SIGNATURE g\g\f\f\R\IR Enrollment Composite.doc - 20131210

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 Mer (Con		Family Coverage (Complete Sections 1, 2 & 3)						
No.	* See Insert fo	or enro	ilment	require	ements			
SECTION 1			MPLOY	EE INF	ORMATI	ON	o de la	
NAME OF EMPLOYER		LOCAL	LUNION				DATE OF HIRE	
SOCIAL SECURITY NO. (required by Federal law)	· · · · · · · · · · · · · · · · · · ·	BIRTH	DATE					
LAST NAME		FIRST	NAME				MIDDLE !NITIAL	
ADDRESS			-				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
CITY		STATE			· · · ·		ZIP CODE	·
PHONE NUMBER		E-MAIL	MAIL ADDRESS					· · · · · · · · · · · · · · · · · · ·
MARITAL STATUS:	SINGLE MARRIED	☐ DIVO	ORCED WIDO		WIDOWE	D T	GENDER:	MALE
☐ CHECK HERE IF THIS	IS A NEW ADDRESS.		CHE	CK HEF	E IF AD	DITIONAL!	MEDICAL CA	☐ FEMALE ARDS ARE NEEDED.
SECTION 2	THE PERIOD OF		SPOUS	E INFO	RMATIO	V		
SPOUSE'S SOC SEC NO. (required by Federal law)		BIRTH DATE		-			MARRIAGE	
LAST NAME		FIRST NAME, MIDDLE (NITIAL					DATE GENDER:	☐ MALE
SPOUSE'S EMPLOYER		PHONE						FEMALE
DOES YOUR SPOUSE HAVE IN	SURANCE THROUGH HIS/HER EMPLO	YER?	☐ YES		NO 🗆	NOT EMPLO	YED	
NAME OF INSURANCE			 .		Ī	PHONE		
GROUP POLICY NUMBER					EFFECT	IVE DATE	<u></u>	
CHECK ALL THE COVERAGES PROVIDED BY SPOUSE'S INSURANCE:				ICAL	L □ RX	☐ DENTAL	☐ VISION	
	ANCE PROVIDE COVERAGE FOR CHIL		☐ YES					
IMPORTANT: Spol	use information is required for Cool	rdination	of Bene	fits purp	oses <u>eve</u>	en if spouse	coverage is	not elected.
SECTION 3A	C	HILD IN	FORMA	TION	FILE	FBCS I	¥ SHL	DOMINE TO M
LAST NAME	FIRST NAME	MI	BIRTH DATE		\TE	GENDE Check O		ELATIONSHIP O EMPLOYEE
Please note that the Adu	it Child Enrollment (section 3B) on the	e back pa	ge must i	also be d	ompleted			through age 25.
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(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. FOR OFFICE USE ONLY								
MEMBER SIGNATURE DATE						unts Receiva		
G:\Groups\Funds\Forms\IR\IR Enrollment To	ier 2.doc - 20110915				-			IR3AB