MILWAUKEE DRIVERS HEALTH & WELFARE TRUST FUND
10020 W. Greenfield Ave.
Milwaukee WI 53214

ENROLLMENT FORM

Telephone 414-258-2336
Toll Free 800-255-3340

PLEASE TYPE OR PRINT. Employee – Complete A, C, D & E

A Self-Funded Health Plan

A. EMPLOYEE INFORMATION

Last Name | First Name | M.I.

Street Address

City | State | Zip | County

Home Phone | Work Phone

Social Security Number

☐ Single ☐ Divorced ☐ Married ☐ Widowed

Date of Birth

Sex ☐ M ☐ F

B. FOR FUND OFFICE USE ONLY

BENEFITS EFFECTIVE DATE:

Plan: A In Area ☑ Out-of-Area ☐

Medical Network:
ANTHEM BLUE PREFERRED PPO

Medical Group #
L08981M001

Dental Group #
52024-000-00000-00000

Rx Group #
MD0003

Routine Vision Group #
9903584

C. FAMILY INFORMATION

List all family members to be covered. Write name as it should appear on I.D. card. Use extra paper if necessary.

Last Name	First Name	M.I.	Relationship	Sex	Birthdate	Social Security Number

D. OTHER HEALTH INSURANCE INFORMATION

On the day your coverage begins will any family members, including those not listed above, be covered by other health or dental insurance or Medicare?
☐ Yes ☐ No If yes, fill out this section. Use extra paper if more than one additional policy will be in force.

Coverage Type: ☐ Medical Insurance ☐ Dental Insurance ☐ Medicare (see below)

Insurance Company Name | Phone Number

Policy Number | Policy Coverage Dates to | Name of Policyholder

Policyholder's Birthdate | Family Members Covered

Policyholder's Employer: Name | Address | Phone Number

Names of Family Members Covered by Medicare | Medicare Claim Number

Part A Effective Date | Part B Effective Date | Is Medicare Eligibility due to: ☐ Kidney Failure ☐ Disability

E. SIGNATURE (This form must be signed)

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application ("Us"), I authorize any health care professional or entity to give the plan or any of their designees any and all records or information pertaining to medical history or services rendered to Us for any administrative purpose, including evaluation of an application or claim, and for any analytical or research purposes. I also authorize on behalf of Us the use of a Social Security Number for the purpose of identification. The information provided on this application is accurate and complete. I understand and agree that any omissions or incorrect statements knowingly made by Us on this application may invalidate my and/or my dependents' coverage.

Signature of Employee | Date Signed

F. FOR FUND OFFICE USE ONLY

Milwaukee Drivers Health and Welfare Trust Fund

Employer Name and Contract Number | Date of Hire

☑ Active Employee ☐ Retiree

Approved By (Signature) | Date