

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.	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced	<b>BENEFITS EFFECTIVE DATE:</b>	
Street Address			<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	Plan: <b>B</b>	In Area <input checked="" type="checkbox"/> Out-of-Area <input type="checkbox"/>
City	State	Zip	County	Date of Birth	Medical Network: <b>ANTHEM BLUE PREFERRED PPO</b>	
Home Phone	Work Phone			Sex <input type="checkbox"/> M <input type="checkbox"/> F	Medical Group # <b>L08981M002</b>	
Social Security Number					Dental Group # <b>52024</b>	
					Rx Group # <b>MD0003</b>	Routine Vision Group # <b>9903584</b>

## 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:	<input type="checkbox"/> Medical Insurance <input type="checkbox"/> Dental Insurance <input type="checkbox"/> 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: <input type="checkbox"/> Kidney Failure <input type="checkbox"/> 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
<input checked="" type="checkbox"/> Active Employee <input type="checkbox"/> Retiree	Approved By (Signature)	Date