

**IRON WORKERS ST. LOUIS DISTRICT COUNCIL WELFARE TRUST FUND
PRESCRIPTION DRUG ENROLLMENT FORM**

EMPLOYEE WORK INFORMATION: To Be Completed By Employee (Please Print)

Company Name:	Date of Employment:	Effective Date of Coverage (Supplied by Administrator of Fund):
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Coverage Type:
 Active Cobra Retired Other

EMPLOYEE PERSONAL INFORMATION:

If address and phone number of covered dependents differ from that of the policy holder, please attach that information.

Name: (Last, First, Middle)	Social Security No.: ____-____-____	Phone No.: Work: () ____-____ Home: () ____-____
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Address: (Street, State, Zip)

Marital Status:
 Single Separated Widowed Married Divorced Maiden Name: _____

PARTICIPANT INFORMATION: Family Members To Be Covered

If "other" is indicated, please indicate the nature of that relationship and include any appropriate legal documents.

Relation	Name			Sex	Date of Birth			Allergies
	Last	First	MI		Mo	Day	Year	
SELF				M F				
SPOUSE				M F				
SON DAUGHTER OTHER				M F				
SON DAUGHTER OTHER				M F				
SON DAUGHTER OTHER				M F				
SON DAUGHTER OTHER				M F				
SON DAUGHTER OTHER				M F				
SON DAUGHTER OTHER				M F				

THIS FORM MUST BE COMPLETED AND RETURNED TO THE FUND OFFICE IN ORDER TO PROVIDE CURRENT DEPENDENT COVERAGE. FAILURE TO DO SO MAY RESULT IN A DELAY IN RECEIVING A CORRECT PRESCRIPTION DRUG CARD.

Iron Workers St. Louis District Council
 Welfare Trust Fund
 2160 S. Foster Avenue
 Wheeling, IL 60090