Chicago & Vicinity Laborers' District Council

Health & Welfare Fund • Retiree Health & Welfare Fund

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DEPENDENT OVER AGE 19 CLAIM FORM

RECEIPT OF THIS FORM DOES NOT GUARANTEE BENEFIT ELIGIBILITY
Failure to complete this form in full may result in delay of payment of your claims.

1. PARTICIPANT INFORMATION

Name: ______________________________ Participant's Alt. ID: _____-_________-_____

2. DEPENDENT INFORMATION

Name: ______________________________

Address, City, State, Zip: ______________________________

Date of Birth: ____________________ Are you employed? ☐ Yes ☐ No

Employer: ______________________________

Employer's Address: ______________________________ Employment Start Date: ____________________

City: ____________________ State: ________ Zip: __________ Employer's Phone: ____________________

Marital Status: **Single:** ☐ **Married:** ☐ **Separated:** ☐ **Divorced:** ☐ **Widow/Widower:** ☐

3. DEPENDENT SPOUSE'S INFORMATION, IF MARRIED

Name: ______________________________

Date of Birth: ____________________ Is your spouse employed? ☐ Yes ☐ No

Employer: ______________________________

Employer's Address: ______________________________ Employment Start Date: ____________________

City: ____________________ State: ________ Zip: ________ Employer's Phone: ____________________

4. OTHER INSURANCE INFORMATION FOR YOURSELF OR SPOUSE

Are you or your spouse insured under any other group hospital or medical plan, Medicare*, or Tricare? **YES** ☐ **NO** ☐

If yes, please provide complete insurance company, carrier, or plan information:

Insurance Company, Carrier, or Plan Name: ______________________________

Address, City, State, Zip: ______________________________

Policy Number: ____________________ Phone Number: ____________________

Primary Insured: ____________________ Primary Insured's ID Number: ____________________

Family members covered under other insurance. Check all that apply: Parent ☐ Self ☐ Spouse ☐

***If you, or your spouse, are eligible for Medicare, you must provide the Fund Office with a copy of your Medicare card(s) when submitting this form.**

It is fraudulent to fill out this form with information you know to be false or to knowingly omit important facts. Criminal and/or civil penalties can result for such an act. If any of the above information is untrue, I agree to reimburse the Health and Welfare Department of the Construction and General Laborers' District Council of Chicago and Vicinity for any money it was induced to pay as a result of the information I provided.

______________________________ ______________________________

Dependent's Signature Date Spouse's Signature (If married) Date