Chicago & Vicinity Laborers' District Council
Health & Welfare Fund • Retiree Health & Welfare Fund

LiUNA! Feel the Power

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BIENNIAL CLAIM FORM AND ENROLLMENT 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: ______________________ SSN: ______________ Participant's Alt. ID: ______________

Address: ______________________ City: ______________________ State: ______ Zip: ________

Date of Birth: _________________ Home Phone: ______________ Cell Phone: ______________

Email: ______________________________________ Local Union Number: ______________

Employer's Name: ______________________________ Employer's Phone: ______________

Employer's Address: ______________________ City: ______________________ State: _____ Zip: ________

Preferred Language: English ☐ Spanish ☐ Polish ☐

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

2. SPOUSE'S INFORMATION

Last Name: ______________________ First Name: ______________ Middle Name: ______________

Date of Birth: ______________ Home Phone: ______________ Cell Phone: ______________

Is your spouse employed? Yes ☐ No ☐ Employment Start Date: ______________

Employer's Name: ______________________________ Employer's Phone: ______________

Employer's Address: ______________________ City: ______________________ State: _____ Zip: ________

3. OTHER INSURANCE INFORMATION FOR YOURSELF, SPOUSE OR DEPENDENT CHILDREN

Are you, your spouse, or dependent children 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: ______________________________________ Policy Number: ______________

City: ______________________ State: _____ Zip: _________ Phone Number: ______________

Primary Insured: ______________________ Primary Insured's ID Number: ______________

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

***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.**

4. ELIGIBLE DEPENDENT CHILDREN / STEPCHILDREN

Names of Eligible Dependents			Birth Date			Relationship	
Last Name	First Name	Initial	Month	Day	Year	Child	Stepchild
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐
						☐	☐

Signature of Participant: _____ Date Signed: _____

Signature of Spouse: _____ Date Signed: _____

5. Complete Beneficiary Designation below when changing an existing beneficiary. If listing more than four, add additional beneficiaries on a new Beneficiary Designation Change Form. Be sure to sign and date each separate form.

Write the full name of the beneficiary, along with their relationship to you, and address, if different from applicant.

A. Name: _____ Social Security Number: _____ Relationship: _____

Address: _____

B. Name: _____ Social Security Number: _____ Relationship: _____

Address: _____

C. Name: _____ Social Security Number: _____Relationship: _____

Address: _____

D. Name: _____ Social Security Number: _____ Relationship: _____

Address: _____

If more than one beneficiary is designated, settlement will be made in equal shares to surviving beneficiaries at time of death of insured, unless otherwise indicated here. Beneficiary A Percentage: _____% Beneficiary B Percentage: _____%
Beneficiary C Percentage: _____% Beneficiary D Percentage: _____%

Signature of Participant: _____ Date Signed: _____

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.