LABORERS' WELFARE FUND

CHICAGO LABORERS' DISTRICT COUNCIL RETIREE HEALTH and WELFARE FUND

11465 CERMAK ROAD
WESTCHESTER, ILLINOIS 60154
PHONE: 708-562-0200

DEPENDENT OVER AGE 19 ANNUAL 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.

PARTICIPANT INFORMATION

Name: Alternate ID No:

DEPENDENT INFORMATION

Name: Social Security No.:_____

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: Married:☐ Single:☐ Separated:☐ Divorced:☐ Widow/Widower:☐

DEPENDENT SPOUSE'S INFORMATION, IF MARRIED

Name: _____ Social Security No.:_____

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

Employer: _____

Employer's Address: _____ Employment Start Date: _____

City: _____ State: _____ Zip: _____ Employer's Phone: _____

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