LABORERS' WELFARE FUND

CHICAGO LABORERS' DISTRICT COUNCIL RETIREE HEALTH AND WELFARE

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

NATURAL PARENT 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: _____ Social Security No.: _____

NATURAL PARENT INFORMATION

Name: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Are you employed?: Yes ☐ No ☐

Employer: _____ Social Security No.:_____

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

Employer's Phone: _____ Employment Start Date: _____

OTHER INSURANCE INFORMATION

Do you insure your dependent children 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: _____

DEPENDENT CHILDREN'S INFORMATION

Name: _____ Date of Birth: _____ Social Security No.: _____

Name: _____ Date of Birth: _____ Social Security No.: _____

Name: _____ Date of Birth: _____ Social Security No.: _____

Name: _____ Date of Birth: _____ Social Security No.: _____

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.

_____ _____

Natural Parent's Signature Date