CHICAGO REGIONAL COUNCIL OF CARPENTERS HEALTH-WELFARE FUND

12 East Erie Street
Chicago, IL 60611
(312) 787-9455

PARTICIPANT'S Statement for Continuation of
Coverage for a Physically or Mentally Disabled Dependent

This form must be completed and returned to the Fund Office.
You will be notified by written letter of approval or denial for continued eligibility.

Please PRINT

Participant's Name:

____
(First, Middle, Last Name)

Participant's SSN# or ID# (ID# is on your BCBS I.D. Card)

____

Participant's Address:

____
(Address) (City, State & Zip Code) (Area Code & Phone Number)

Disabled Dependent's Name:

____
(First, Middle, Last Name)

Disabled Dependent's Date of Birth:

_______/________/________
Month Day Year

Male ☐
Female ☐

This is to certify that: ____
(Disabled Dependent's Name)

(a) is my unmarried child;
(b) is mentally or physically incapable of earning his own living;
(c) became so incapable prior to the attainment of the limiting age for coverage of children under this policy;
(d) is chiefly dependent upon me for support and maintenance; and
(e) I request continuation of coverage for my dependent which would otherwise terminate on the attainment of the limiting age.

When did the incapacity begin:

______/_______/_______

Is the child dependent on you for Support ☐ **Yes** ☐ **No**
If Yes, what percent? _________**%**

Is the child listed on your last Federal Tax Return ☐ **Yes** ☐ **No**

Provide:
Physician's Name: ___________________________________

Address:____

City, State & Zip____

Area Code & Phone Number____________________________

Is the child permanently residing in your household?
☐ **Yes** ☐ **No**
If no, why not?

Where does the child live?

Is the child covered under any other hospital or medical coverage:

☐ **Yes** ☐ **No**

If yes, give the name of the insurance companies and policy numbers:

Spouses Name:

Spouses Date of birth

What is the nature of the incapacity?

I, the Fund Participant, hereby certify that the information I provided is true and accurate. If any of the above information is untrue, I agree to reimburse the Chicago Regional Council of Carpenters Welfare Fund for any money it was induced to pay as a result of the information I provided.

The Chicago Regional Council of Carpenters Welfare Fund is authorized to contact my child's attending physician and obtain the necessary information concerning my child's incapacity. I further authorize any medical professional, hospital or other medical care institution, insurance support organization, pharmacy, government agency, insurance company, group policyholder, employer or benefit plan administrator to provide the Chicago Regional Council of Carpenters Welfare Fund with any information concerning the medical advice, care or treatment provided (insert child's name) ________________________________ , and any employment-related information. I understand that such information will be used to evaluate my claim for benefits and that I, or my representative, will receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Participant's Signature: ____ **Dated**: _____/_____/______
Month Day Year

(Please be sure to read IMPORTANT NOTE on reverse side of this form)

IMPORTANT NOTE

The Chicago Regional Council of Carpenters Welfare Fund reserves the right to request proof of disability or handicap from time to time and shall have the right and opportunity, at its own expense, to require an independent medical examination of the disabled dependent child when and as often as it may reasonably require during the continuation of such incapacity.

Coverage for the child will automatically terminate on the earliest date of the following: (i) the date of cessation of such incapacity; (ii) the date of failure to furnish any required proof of the uninterrupted continuance of such incapacity or to submit to any required examination; or (iii) the date of termination of coverage as to the child, for reason other than the attainment of the limiting age, as provided in the Summary Plan Description.

If the inclusion of the child for coverage, as of a current date, requires a monthly premium or an increase to an existing premium, the Participant will be advised of that fact by the Fund Office.

Questions regarding this form may be directed to:

The Chicago Regional Council of Carpenters Welfare Fund
Attn: Health and Welfare Department
12 East Erie Street
Chicago, IL 60611
312-787-9455, phone option 3