



Service. Security. Stability.

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

12 EAST ERIE STREET • CHICAGO, IL 60611

(312) 787-9455, OPTION 3

FAX: 312-951-1515



* P I F *

Participant Information Form

Instructions: **Print Clearly in Ink.** This form must be completed in full, signed and returned to the Fund Office. You may also fax the completed form to the above number. **Failure to complete this form in full** will result in the form being returned to you and a delay of payment of your benefits.

Part 1 – Participant Information					
1. Participant's Last Name		First	Middle Initial	2. Soc. Sec. Number or Individual Tax ID Number (ITIN):	
				3. BCBS I.D. Number	
4. Participant's Home Address			5. City	6. State	7. Zip Code
8. Date of Birth: / /		9. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		10. Martial Status: (Please check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed	
11. Telephone Number: ()			12. Cell Phone Number: ()		
13. Email Address:			14. Are you on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare Claim/Tricare Card Number (HIC):		
Part 2 – Spouse Information					
1. Spouse's Last Name			First	Middle Initial	2. Soc. Sec. Number or Individual Tax ID Number (ITIN) (Mandatory):
3. Date of Birth / /		4. Telephone Number: ()		5. Are you on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):	
6. Is Spouse Employed?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Employer:				7. Employers Telephone Number ()	
8. Employer's Address			9. City	10. State	11. Zip Code
Part 3 – Dependent Children Information. Complete all information or the form will be returned to you as incomplete.					
1a. Child's Last Name		First	Middle Initial	1b. Child's Date of Birth / /	
				1c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
				1d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other:	
1e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address:			1f. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
		City: State:			
2a. Child's Last Name		First	Middle Initial	2b. Child's Date of Birth / /	
				2c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
				2d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other:	
2e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address:			2f. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
		City: State:			
3a. Child's Last Name		First	Middle Initial	3b. Child's Date of Birth / /	
				3c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
				3d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other:	
3e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address:			3f. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
		City: State:			
4a. Child's Last Name		First	Middle Initial	4b. Child's Date of Birth / /	
				4c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
				4d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Other Explain Other:	
4e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address:			4f. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
		City: State:			
5. Do you need to list more dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list them on a separate piece of paper and return with this form.					
Part 4 – Other Insurance Information					
1. Are you, your Spouse or Dependent Children insured under any other Group Hospital, Medical, Dental or Visions Plan?: <input type="checkbox"/> Yes <input type="checkbox"/> No			2. If yes, Name of Insurance Carrier:		
3. Policy Number:		4. Insurance Carrier's Phone Number: ()		5. Family members insured under the Group Insurance Policy (check all that apply): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> All Children <input type="checkbox"/> Child List name(s):	
PLEASE SEND A COPY OF THE FRONT & BACK OF OTHER INSURANCE AND/OR MEDICARE CARD WHEN YOU RETURN THIS FORM					
Statement: It is fraudulent to fill out this form with information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. 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. Receipt of this form is not a guarantee of eligibility.					
X Participant's Signature			X Spouse's Signature		
Date			Date		