



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



2010 Participant Information Form

Instructions: **Print Clearly in Ink.** You must complete the form in full, sign and return it to the Fund Office at the above address. 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: City: State:			1f. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
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: City: State:			2f. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
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: City: State:			3f. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
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: City: State:			4f. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
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 Date

X _____
Spouse's Signature Date