

LABORERS'
WELFARE
FUND

**HEALTH and WELFARE DEPARTMENT of the CONSTRUCTION and
GENERAL LABORERS' DISTRICT COUNCIL of CHICAGO and VICINITY**

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