

**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: \_\_\_\_\_ Social Security 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