Your Future — Our Focus

**CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND**

12 EAST ERIE STREET • CHICAGO, IL 60611

(312) 787-9455, OPTION 3

FAX: 312-951-1515

# Dependent Removal Form

Instructions: **Print Clearly in Ink**. In order to remove a dependent from the health plan, this form must be completed and returned to the above address, to the attention of the Health Benefits Department.

Participant's Name: _____ Participant's UID: _____
(First, Middle, Last) (UID can be found on your BCBS I.D. card)

Dependent's Name: _____ Dependent's Date of Birth: ____/____/_____
(First, Middle, Last) Month Day Year

Dependent's Relationship to the Participant:

☐ Spouse ☐ Son ☐ Daughter
☐ Stepchild ☐ Other (explain):

Reason for removing dependent:

_____
_____
_____

Please terminate _____ from coverage effective _____ for the
(Dependent's Name) (Termination Date)
above reason. I understand that by completing this form, the above named dependent will no longer be eligible for benefits under the Chicago Regional Council of Carpenters Welfare Plan. Should I wish to reinstate coverage for the above named dependent, I understand supporting documentation may be required.

Participant's Signature: _____ Date: _____/_____/_____

**FUND OFFICE USE ONLY:**

Date Received Date Approved Date Scanned