CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

12 EAST ERIE STREET • CHICAGO, IL 60611
(312) 787-9455, PHONE OPTION 3

Participant's Statement for Continuation of Coverage for a Physically or Mentally Disabled Dependent

Instructions: **Print Clearly in Ink**. You must complete the form in full, sign and return it to the Fund Office in the enclosed envelope. **Failure to complete this form in full** will result in the form being returned to you and a delay of payment of your disabled dependent's claims.

Part 1 – Participant Information

1. Participant's Last Name First Middle Initial	2. Soc. Sec. Number, ID 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. Participant's Date of Birth / /	9. Gender: ☐ Male ☐ Female	10. Martial Status: (Please check one) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
11. Telephone Number ( )	12. Cell Phone Number ( )	13. Email Address	
14. Spouse's Name	15. Spouse's Date of Birth / /	16. Spouse's Soc. Sec. Number	

Part 2 – Disabled Dependent's Information. Complete all information or the form will be returned to you as incomplete.

1. Disabled Dependent's Last Name First Middle Initial	2. Dependent's Date of Birth / /	3. Dep. Soc. Sec. #	4. Dependent's Gender: ☐ Male ☐ Female

5. Relationship to Participant: ☐ Son ☐ Daughter ☐ Step Child ☐ Other Explain Other:

6. Is the disabled dependent permanently residing in your household? ☐ Yes ☐ No	7. If the disabled dependent does not live with you, why not?

8. If the disabled dependent does not live with you, where does the disabled dependent live?
Name of Person or Facility Dependent is living with: Address: City, State & Zip Code:

8. When did the disability begin: / /	9. Is the disabled individual dependent on you for Support? ☐ Yes ☐ No If Yes, what percent? %	10. Is the disabled dependent listed on your last Federal Tax Return? ☐ Yes ☐ No

11. What is the nature of the disability?

12. Dependent's Primary Physician's Name Address City, State & Zip	13. Phone Number: ( ) -

Part 3 – Other Insurance Information

1. Is the Disabled Dependent insured under any other **Group** Hospital, Medical, Dental or Visions Plan? ☐ Yes ☐ No (If yes, circle type of coverage)

2. If yes, Name of Insurance Carrier:	3. Policy Number	4. Insurance Carrier's Phone Number: ( )

5. Is the Disabled Dependent on Medicare or Tricare? ☐ Yes ☐ No If yes, provide Medicare/Tricare Card Number (HIC):

*****PLEASE SEND A COPY OF THE FRONT & BACK OF OTHER INSURANCE AND/OR MEDICARE CARD WHEN YOU RETURN THIS FORM*****

This is to certify that: ____
(Disabled Dependent's Name)

(a) is my unmarried child;
(b) is mentally or physically incapable of earning his own living;
(c) became physically or mentally disabled prior to the attainment of the limiting age for coverage of children under this policy;
(d) is chiefly dependent upon me for support and maintenance; and
(e) I request continuation of coverage for my dependent which would otherwise terminate on the attainment of the limiting age.

I, the Fund Participant, hereby certify that the information I provided is true and accurate. 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.

The Chicago Regional Council of Carpenters Welfare Fund is authorized to contact my child's attending physician and obtain the necessary information concerning my child's disability. I further authorize any medical professional, hospital or other medical care institution, insurance support organization, pharmacy, government agency, insurance company, group policyholder, employer or benefit plan administrator to provide the Chicago Regional Council of Carpenters Welfare Fund with any information concerning the medical advice, care or treatment provided my disabled dependent listed above and any employment-related information. I understand that such information will be used to evaluate my claim for benefits and that I, or my representative, will receive a copy of this authorization upon request and agree that a photographic copy of this authorization is as valid as the original.

Participant's Signature: ______________________________ **Dated**: ______/______/______
Month Day Year

IMPORTANT NOTE

The Chicago Regional Council of Carpenters Welfare Fund reserves the right to request proof of disability or handicap from time to time and shall have the right and opportunity, at its own expense, to require an independent medical examination of the disabled dependent child when and as often as it may reasonably require during the continuation of such incapacity.

Coverage for the child will automatically terminate on the earliest date of the following: (i) the date of cessation of such incapacity; (ii) the date of failure to furnish any required proof of the uninterrupted continuance of such incapacity or to submit to any required examination; or (iii) the date of termination of coverage as to the child, for reason other than the attainment of the limiting age, as provided in the Summary Plan Description.

If the inclusion of the child for coverage, as of a current date, requires a monthly premium or an increase to an existing premium, the Participant will be advised of that fact by the Fund Office.

Questions regarding this form may be directed to:

The Chicago Regional Council of Carpenters Welfare Fund
Attn: Health Benefits Department
12 East Erie Street
Chicago, IL 60611
312-787-9455, Phone Option 3