Instructions for Enrolling a Dependent Child
in the Chicago Regional Council of Carpenters Welfare Fund
Retiree Plan of Benefits

1. **Review the List of Dependent Definitions and Required Documents** to determine if your dependent meets the definition of a dependent child. If your dependent meets the criteria, proceed to step #2 below. Remember you must submit the required supporting documents (for example, a birth certificate for a child) to the Retirement Benefits Department.

2. **Complete the Enrollment Form in its entirety**. Print clearly **in ink** and answer all questions. Enrollment will be delayed if the form is not legible or if a question is left unanswered. (Note: If your dependent child has other insurance, you must make a copy of his/her insurance card and return it with the completed Enrollment Form.)

3. **The carpenter must sign and date the form.** The form is not valid without a signature.

4. **Submit the completed Enrollment Form and all required documents necessary for enrollment to**:

   Chicago Regional Council of Carpenters Welfare Fund
   Attn: Retirement Benefits Department
   12 East Erie Street – 8th Floor, Chicago, IL 60611

Please consider the following:

- You must enroll a new dependent child within ninety (90) days of the date the child becomes your dependent. Coverage begins on the date the child becomes your dependent, and you are responsible for any required premium(s) for the full month during which coverage under the Retiree Plan begins.

- If you did not enroll the dependent child within ninety (90) days of date the child became your dependent, or at the time of your retirement (if later), late enrollment for the dependent child will only be considered in circumstances where the child has been continuously covered by another health plan. You must submit **either** a Certificate of Creditable Coverage from the other health plan **OR** have the attached Continuous Coverage Verification form completed by the other health plan or employer. If your dependent was covered under more than one other health plan during the postponement period, you will need to provide documentation for each of the health plans. You must enroll your dependent within ninety (90) days of the date coverage under the other health plan ended. Coverage under the Retiree Plan will begin on the first day of the month in which the other health care plan terminates. However, if the other health care plan terminates on the last day of the month, coverage under the Retiree Plan generally begins on the first day of the following month. You are responsible for payment of any required premium(s) for the full month during which coverage under the Retiree Plan begins.

- Coverage for a dependent child is contingent upon your eligibility as well the child meeting the conditions for benefit coverage. Your child can only be enrolled in the same type of coverage in which you are enrolled. For example, if you are only enrolled in the Prescription Drug benefit, then that is the only benefit in which you can enroll your dependent child.

Carefully review your coverage options and the Plan provisions before completing the enrollment form. The Summary Plan Description ("SPD") is available on the Fund's website at www.crccbenefits.org. On the home page, select "Benefit Info – Retiree." You will find a link to the SPD under the Eligibility & Enrollment tab. A SPD will automatically be mailed to you once the enrollment is processed. You may also contact the Retirement Benefits Department to request a hardcopy of the SPD.

FREQUENTLY ASKED QUESTIONS

Enrollment for Dependent Children

Retiree Plan of Benefits

1. When can I add a new dependent to my coverage?
You must enroll a new dependent in coverage within 90 days of the date the child becomes your dependent.

2. If I want to add my dependent to my coverage at a later date, will I be allowed to do so?
As long as you, the retired carpenter, are eligible for benefits, you may enroll your child at a later date if your child had continuous coverage through another health plan from *the later of* (1) the date the child became your dependent or (2) the date of your retirement until the date of the child's enrollment in the Retiree Plan of Benefits. Proof of continuous coverage from the other health plan is required in the form of **either a Certificate of Creditable Coverage OR the attached Continuous Coverage Verification form (completed by the other health plan or the employer).**

3. What are the Plan's requirements for enrollment of a dependent child?
A fully completed and signed Enrollment Form and an original county certified birth certificate which lists the participant (carpenter) as one of the parents. *The above is not meant to be an all-inclusive list. Additional documents are required for step children. Full details are provided on the Definitions and Required Documents listing.*

4. Does the Fund require original documentation for enrollment?
Yes. Original documents are required. However, after the Retirement Benefits Department images the documents, they will be returned to you via delivery confirmation through the U.S. Post Office.

5. How do I submit the required documents?
You may either hand-deliver or mail original documents to the Fund Office at: Chicago Regional Council of Carpenters Welfare Fund, Attn: Retirement Benefits Department, 12 East Erie Street, 8th Floor, Chicago, IL 60611. The originals will be returned to you via delivery confirmation through the U.S. Post Office.

6. When must I submit the enrollment form and the required documents?
The enrollment form and all of the required supporting documents **must** be submitted to the Retirement Benefits Department within ninety (90) days of the date you acquire the new dependent OR within ninety (90) days of the date of the date coverage for the dependent under another health insurance plan ends.

7. Will I receive verification that my dependent child's enrollment was processed?
Yes, the Retirement Benefits Department will mail a confirmation to your home address after enrollment is complete.

8. Who can answer my questions about the requirements to add a dependent child?
Any one of the Retirement Benefit Representatives can answer your questions. Call the Fund Office at 312-787-9455, telephone option 4, Monday through Friday, between 8:00 a.m. and 4:30 p.m.

9. Who can I enroll?
Provided that you supply all of the required documents and your child meets the definition of a dependent child, you may enroll your biological, adopted or step child.

10. Can I enroll my *adult* dependent child who is married but younger than age 26?
Yes. However, the Fund will not cover your adult dependent's spouse or their children. For details see the Definitions and Required Documents listing.

11. Can I enroll my *adult* dependent child who does not live with me and who is not financially dependent on me?
Yes. Living with you or being financially dependent on you is not a requirement, unless the dependent is a step-child. For details see the Definitions and Required Documents listing.

12. Can I enroll my *adult* dependent child who has insurance through his/her employer?
Yes your adult dependent child can be covered under this Plan and a second plan. However, the coverage available through your dependent's employer is the primary carrier and the Fund will pay second.

13. What if my spouse's health care plan offers dependent coverage?
In the event your spouse's health care plan offers dependent child coverage as well, coordination of benefit payment between plans will follow the rules provided in the Summary Plan Description.

14. In what type of coverage may I enroll my dependent child?
Your child can only be enrolled in the same type of coverage that you elect. For example, if you are only enrolled in the Prescription Drug benefit, then that is the only benefit in which you can enroll your dependent child.

15. Do I need to pay a premium for coverage for my dependent child?
Yes. The premium for coverage for your dependent child will be deducted from your monthly pension payment. You are responsible for payment of any required premium(s) for the full month during which coverage under the Retiree Plan begins. In rare cases, the total monthly premium amount may be greater than the monthly pension amount. If this occurs, special arrangements will be made to allow you to submit payments for the difference in the amounts. If this applies to you, the Retirement Benefits Department will contact you regarding payment submission after all of the required enrollment materials are received.

16. What are the premiums for coverage?
Please refer to the attached Retiree Health Benefit Premium sheets. Be aware that all premiums may increase in the future.

Chicago Regional Council of Carpenters Welfare Fund

12 East Erie Street, Chicago, Illinois 60611 (312)787-9455, Menu Option #4

RETIREE HEALTH BENEFIT PREMIUMS

(Premiums Effective January 1, 2011)

For those who meet the eligibility requirements for Retiree Health Benefits, the Comprehensive Medical Benefit monthly premiums and the Prescription Drug Benefit monthly premiums will be determined by the number of years of Vesting Credit that a participant has earned. (A maximum of one year of Vesting Credit can be earned per calendar year.) Current Retiree Premiums appear in the following chart**. Note that these premiums may increase in the future.**

IMPORTANT:

- No coverage is provided under the Retiree Plan of Benefits for: life insurance; accidental death & dismemberment insurance; weekly sickness & accident disability benefits; or vision benefits.
- "Active" Carpenter Plan Deductibles and/or Out of Pocket Coinsurance Maximums do not carry over to the Retiree Plan.
- Retiree coverage does not include the ComPsych Network. Coverage for mental health/substance abuse is considered under the Comprehensive Medical Benefits, subject to the Retiree Plan's PPO & non-PPO deductibles and co-payments

Years of Vesting Credit	Per Person Per Month Premium for **Non-Medicare Eligible Comprehensive Medical Benefits**	Per Person Per Month Premium for **Medicare Eligible Comprehensive Secondary Medical Benefits**	Per Person Per Month Premium for **Prescription Drug Coverage**
10	300.00	80.00	106.00
11	294.00	77.00	106.00
12	289.00	76.00	106.00
13	284.00	75.00	106.00
14	278.00	74.00	106.00
15	273.00	72.00	96.00
16	267.00	70.00	96.00
17	262.00	69.00	96.00
18	257.00	67.00	96.00
19	251.00	65.00	96.00
20	246.00	64.00	86.00
21	241.00	62.00	86.00
22	235.00	61.00	86.00
23	230.00	59.00	86.00
24	225.00	57.00	86.00
25	219.00	56.00	75.00
26	214.00	55.00	75.00
27	209.00	52.00	75.00
28	203.00	51.00	75.00
29	198.00	50.00	75.00
30 or more	187.00	47.00	75.00

(OVER)

DISABILITY PENSIONERS – SPOUSE & DEPENDENT PREMIUMS

The monthly Retiree Health Care Benefit premium rate **for spouses and dependent children of pensioners receiving Disability pensions** are **not** based on the number of years of earned Vesting credit.

The current premiums are as follows and may increase in the future:

- $170.00 per person per month for Comprehensive Major Medical coverage
- $55.00 per person per month for prescription drug coverage

The premium charged for you, the disability pensioner, will still be determined in accordance with the tiered premium structure.

If your spouse or dependent child is now or later becomes eligible for Medicare, the premium for your spouse or dependent is or will be determined by the tiered premium structure.

DENTAL PLAN

(Premiums Effective April 1, 2017)

If an individual enrolls in dental coverage, has services, and then cancels coverage before being enrolled in dental coverage for at least one full year, the Trustees prohibit re-enrollment for a period of two years.

	Monthly Premium
One Individual Enrolled	$ 42.92
Two Individuals Enrolled	$ 83.30
Family (3 or more) Enrolled	$147.80

VISION PLAN

(Premiums Effective April 1, 2017)

If an individual enrolls in vison coverage, has services, and then cancels coverage before being enrolled in vison coverage for at least one full year, the Trustees prohibit re-enrollment for a period of two years.

	Monthly Premium
One Individual Enrolled	$ 6.16
Two Individuals Enrolled	$ 12.01
Family (3 or more) Enrolled	$17.99

COBRA OPTION

(Premiums Effective February 1, 2017)

Please note that the COBRA coverage option is only available to those who are still eligible for the Carpenter's Active Plan of Benefits at the time they retire.

If you are eligible for the Carpenter's Active Plan of Benefits at the time you retire, you have the option of continuing your Active Plan under the COBRA option. Generally, COBRA coverage runs for a maximum of 18 months or until an individual becomes eligible for Medicare. If you elect the COBRA option, the Retiree Plan of Benefits would not begin until the month after the COBRA coverage ends. If you do NOT elect the COBRA option, the Retiree Plan of Benefits would begin the month after your Active Plan benefits end.

	Individual Premium Per Month	**Family Premium Per Month**
Hospital, Surgical, Major Medical, Prescription, Hearing, Routine Physical, Dental and Vision Coverage	$548.00	$1,354.00
All above coverage except Vision and Dental Benefits	$493.00	$1,218.00

(OVER)

SURVIVING SPOUSE'S HEALTH BENEFIT CONVERSION

When the carpenter dies, continuation coverage under COBRA is offered to the surviving spouse. Continuation coverage under COBRA is the same coverage that the surviving spouse had before the carpenter died.

Continuation coverage under COBRA can include dental coverage if the surviving spouse was covered under the Dental Plan at the time of the carpenter's death. *From April 2017 through March 2018, continuation coverage under COBRA that includes the Dental Plan costs an additional $42.92 per month.*

After April 1, 2017, continuation coverage under COBRA can include vision coverage if the surviving spouse was covered under the Vision Plan at the time of the carpenter's death. *From April 2017 through March 2018, continuation coverage under COBRA that includes the Vision Plan costs an additional $6.16 per month.*

Note that premiums may increase in the future.

(Premiums Effective February 1, 2017)

Type of Coverage	Monthly Premium
Medicare Eligible Surviving Spouse with Comprehensive Medicare Supplement coverage, **including** Prescription Drug coverage	$246.00 per month
Medicare Eligible Surviving Spouse with Comprehensive Medicare Supplement coverage, **without** Prescription Drug coverage	$111.00 per month
Non- Medicare Eligible Surviving Spouse with Comprehensive Medical Benefit coverage, **including** Prescription Drug coverage	$628.00 per month
Non- Medicare Eligible Surviving Spouse with Comprehensive Medical Benefit coverage, **without** Prescription Drug coverage	$463.00 per month
Prescription Drug Coverage Only	$135.00 per month

Your Future — Our Focus

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

ACTIVE & RETIREE PLAN OF BENEFITS

DEFINITIONS AND REQUIRED DOCUMENTS

Note: All original documents submitted to the Fund Office will be returned to you via Delivery Confirmation through the U.S. Post Office.

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENTS
Spouse	Your lawful spouse (if not legally separated)	Marriage Certificate (**original county certified**). **Note**: • Only an original county certified marriage certificate will be accepted. Other certificates, such as a certified domestic partner certificate, a civil union certificate, or a church marriage document are not acceptable.
Child younger than age 26	A biological or legally adopted child placed before the age of 18, whether married or unmarried. Note: Legally adopted children are eligible for benefits when they are placed for adoption. A child is placed for adoption with you on the date you first become legally obligated to provide full or partial support of the child you plan to adopt.	• Birth Certificate (**original county certified**) listing the carpenter as a parent, OR • **Original** Foreign Birth Certificate from country of birth, OR • **Original** Court ordered Placement for Adoption, OR • **Original** Final Adoption Order signed by a judge, OR • **Original** International adoption papers from country of birth, OR • Amended birth certificate (**original county certified**) listing the carpenter as a parent, OR • Qualified Medical Child Support Order (QMSCO) or National Support Notice issue by the State child support agency medical benefit coverage generally applies only through age 18 (where applicable).
Stepchild younger than age 26	A stepchild for whom the participant provides more than one-half of the total support for such child and the stepchild must reside with the Participant for more than one-half of the Calendar Year. Note: Primary coverage for a stepchild is provided only in the event no other group health coverage is available through the parents and that neither of the biological/adoptive parents are obligated to provide health coverage.	• Birth Certificate of stepchild (**original county certified**), AND • Stepchild Dependent Affidavit, **AND one of the following documents:** • Divorce Decree - the first page, last page (with the official stamp to show proof filed with the court) and all sections relating to medical insurance and custody, OR • Death certificate (**original county certified**), if parent is deceased, OR • Notarized letter from the parent stating that the stepchild's parents were never married.

DEPENDENT TYPE	DEFINITION	REQUIRED DOCUMENTS
Disabled child age 26 and older	An unmarried biological or legally adopted child placed before the age of 18, with a physical or mental disability provided that: • The disability is permanent; • The disability began before the child attained age 19 and while the child was covered as a Dependent under the Plan; and • The child must be dependent on the participant for more than 50% of his/her financial support and maintenance. Note: A child is considered disabled if he is not capable of self-support because of a physical or mental impairment.	• Birth Certificate (**original county certified**) listing the carpenter as a parent, OR • **Original** Foreign Birth Certificate from country of birth, OR • **Original** Court ordered Placement for Adoption, OR • **Original** Final Adoption Order signed by a judge, OR • **Original** International adoption papers from country of birth, OR • Amended birth certificate (**original county certified**) listing the carpenter as a parent; AND • A completed **Participant Statement for Continuation of Coverage for a Physically or Mentally Disabled Dependent** form**,** **AND one of the following documents:** • A completed **Attending Physician's Statement for Continuation of Coverage for a Physically or Mentally Disabled Dependent** form certifying total and permanent disability OR • Notice of Determination/Award of Disability from the Social Security Administration; OR • Medicare Identification Card for dependent.
Disabled stepchild age 26 and older	An unmarried stepchild with a physical or mental impairment provided that: • The disability is permanent; • The disability began before the stepchild reached age 19 and while the stepchild was covered as a Dependent under the Plan; and • The participant must attest to the Fund that he/she provides more than one-half of the total support for the stepchild and the stepchild must reside with the Participant for more than one-half of the Calendar Year. Note: • A stepchild is considered disabled if he is not capable of self-support because of a physical or mental impairment. • Primary coverage for a stepchild is provided only in the event no other group health coverage is available through the biological/adoptive parents and that no other individual is obligated to provide health coverage.	• Birth Certificate(**original county certified**), AND • Stepchild Dependent Affidavit, AND • A completed **Participant Statement for Continuation of Coverage for a Physically or Mentally Disabled Dependent** form**,** **AND one of the following documents:** • A completed **Attending Physician's Statement for Continuation of Coverage for a Physically or Mentally Disabled Dependent** form certifying total and permanent disability, OR • Notice of Determination of Disability from the Social Security Administration, OR • Medicare Identification Card for dependent **AND one of the following documents:** • Divorce Decree- the first page, last page (with the official stamp of the court) and all sections relating to medical insurance and custody, OR • Death certificate (**original county certified**), if parent is deceased, OR • Notarized letter from the parent covered under the Plan stating that the stepchild's parents were never married.

RESOURCES TO OBTAIN DOCUMENTS:

Birth Certificates: www.idph.state.il.us/vitalrecords/index.htm

If you have questions, please call the Health Benefits Department at 312-787-9455 - Telephone Option #3.
Retired Participants should call the Retirement Benefits Department at 312-787-9455, Telephone Option #4.

Your Future — Our Focus

Chicago Regional Council of Carpenters
Welfare, Pension and Supplemental Retirement Funds

12 East Erie Street • Chicago, Illinois 60611
(312) 787-9455 • Kristina M. Guastaferri, Administrator
www.crccbenefits.org

NONDISCRIMINATION STATEMENT

The Chicago Regional Council of Carpenters Welfare Fund (the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The Plan provides language assistant services to persons whose primary language is not English, and free aids and services where necessary to people with disabilities to communicate effectively with us. If you need these services, contact the Fund Office.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Fund Office by mail, telephone or in person at: Chicago Regional Council of Carpenters Welfare Fund, Attn: Cindy Rivera, Civil Rights Coordinator, 12 E. Erie Street, Chicago, IL 60611, Phone: 312-787-9455.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

* * *

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-312-787-9455.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-312-787-9455.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-312-787-9455.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-312-787-9455 (번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-312-787-9455.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-312-9455-787

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-312-787-9455.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-312-787-9455.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-312-787-9455.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-312-787-9455.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-312-787-9455.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-312-787-9455 पर कॉल करें।

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-312-787-9455.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-312-787-9455.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-312-787-9455.

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
RETIREE PLAN OF BENEFITS
12 East Erie Street, Chicago, IL 60611
(312) 787-9455 – Option 4

* I N S M A I N T *

Enrollment Form for a Dependent Child

Instructions: **Print Clearly in Ink**. This 2 page form is used to enroll a dependent in the Retiree Healthcare Benefits. A separate form must be completed for each dependent. If you require an additional form, one can be downloaded from our website at www.crccbenefits.org. The retired carpenter must complete this form in full, sign and date it. Both pages of the completed form and all of the required supporting documentation must be submitted to the Retirement Benefits Department.

Carefully review your coverage options and the Plan provisions before completing this form. The Summary Plan Description ("SPD") is available on the Fund's website at www.crccbenefits.org. On the home page, select "Benefit Info – Retiree." You will find a link to the SPD under the Eligibility & Enrollment tab. A SPD will automatically be mailed to you once your dependent's enrollment is processed. You may also contact the Retirement Benefits Department to request a hardcopy of the SPD.

Retired Participant's Name:	**Retired Participant's SSN# or UID#** (UID# is on BCBS I.D. Card)	
Retired Participant's Street Address, City, State & Zip:		
Retired Participant's E-Mail Address:	**Retired Participant's Home Phone Number:**	**Retired Participant's Cellular Phone Number:**
Dependent's Name:	**Dependent's SSN:**	**Dependent's Date of Birth:**
Dependent's Street Address, City, State & Zip:		

Is this Dependent employed? __Yes __No **If yes, provide employer name and telephone number:**	**Does this Dependent have other insurance? ___ Yes ___No** **If yes, provide insurance information below**:	**Is this Dependent Covered By Medicare? ___Yes ___No** **If yes, provide Medicare ID number and copy of Medicare card.**

Name of other insurance: _____

Address of other Insurance: _____

Policy Number: _____ **Insurance Company Phone Number:** _____

Affix a copy of dependent's insurance card to this form.

(TURN PAGE OVER)

Receipt of this form does not guaranty eligibility.

THIS FORM IS NOT VALID WITHOUT A SIGNATURE AND DATE

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND RETIREE PLAN OF BENEFITS

12 East Erie Street, Chicago, IL 60611
(312) 787-9455 – Option 4

Enrollment Form for a Dependent Child

Coverage Election - Your Dependent Child can only be enrolled in the type of coverage in which you are enrolled.

Part A
Choose One
△ My Dependent is NOT currently Medicare Eligible
△ My Dependent is currently Medicare Eligible (You must submit a copy of your Dependent's Medicare card)

Part B
Choose One
O I elect to enroll my Dependent in the Comprehensive Medical Benefit *(or Hospital only coverage if you, the retired carpenter, are covered by the Hospital only coverage and are not eligible for the Comprehensive Medical Benefit)*
O I do NOT elect to enroll my Dependent in the Comprehensive Medical or Hospital Only Benefit coverage
O My dependent is covered by another comprehensive medical benefit plan and elects to postpone coverage in the Welfare Fund's Comprehensive Medical Benefits coverage until coverage under the other plan ends.

Part C
Choose One
☐ I elect to enroll my Dependent in the Prescription Drug coverage
☐ I do NOT elect to enroll my Dependent in the Prescription Drug coverage
☐ My dependent is covered by another prescription drug plan and elects to postpone coverage in the Welfare Fund's Prescription Drug coverage under the other plan ends.

Part C
Choose One
◇ I elect to enroll my Dependent in the Dental coverage
◇ I do NOT elect to enroll my Dependent in the Dental coverage
◇ My Dependent is covered by another dental plan and elects to postpone enrollment in the Welfare Fund's Dental coverage until coverage under the other plan ends.

Part E
Choose One
△ I elect to enroll my Dependent in the Vision coverage
△ I do NOT elect to enroll my Dependent in the Vision coverage
△ My Dependent is covered by another vison plan and elects to postpone enrollment in the Welfare Fund's Vision coverage until coverage under the other plan ends.

Part F
Choose One
△ Biological Child △ Legally Adopted Child △ Stepchild

Please see the Definitions and Required Documents listing for instructions regarding the documents that must be submitted with this form.

Statement: I understand that enrolling my dependent child in my coverage is contingent upon my own eligibility for benefits as well as the requirement that this completed form and all required supporting documentation be submitted to the Retirement Benefits Department.

I hereby authorize **either** the Chicago Regional Council of Carpenters Pension Fund **or** the Chicago Regional Council of Carpenters Millmen Pension Fund **or** the Carpenters Pension Fund of Illinois **or** the Carpenters Local #496 Pension Fund (hereafter referred to as "Pension Fund") to deduct the appropriate premium(s) from my monthly pension benefit for the coverage under the Chicago Regional Council of Carpenters Welfare Fund Retiree Plan of Benefits ("Welfare Fund") that I have elected. I understand that premium rates may increase at any time. If premiums increase under the Welfare Fund, the Pension Fund is authorized to withhold the increased premium amount from my pension payment.

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 information that I have furnished on this form is untrue or incomplete, 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.

Signature of Participant: _____ **Date**: _____

Receipt of this form does not guaranty eligibility.

THIS FORM IS NOT VALID WITHOUT A SIGNATURE AND DATE

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
RETIREE PLAN OF BENEFITS
12 East Erie Street, Chicago, IL 60611
Telephone: (312) 787-9455 – Option 4
Facsimile: (312) 951-3986
Email: pension@crccbenefits.org

PAGE 1 of 2 -- Continuous Coverage Verification Form for Enrollment in the Retiree Health Care Benefits

Retired Carpenter's Name:	Retired Carpenter's SSN# or UID#:

The Chicago Regional Council of Carpenters Welfare Fund Retiree Plan of Benefits ("Retiree Plan") permits retirees and their dependents to postpone enrollment in the Retiree Plan when they have other health plan coverage. They can later enroll in coverage under Retiree Plan if they can provide evidence that they maintained continuous coverage under another health plan during the postponement period. Enrollment in the Retiree Plan is now being requested. In order to process the enrollment, this form must be completed by either the Health Plan or the Employer as evidence of continuous healthcare coverage during the postponement period.

Authorization for Release of Information
The Covered Individual Must Sign and Date This Section Before Sending to the Health Plan or Employer for Completion

I recognize that my health plan eligibility information may be protected under the HIPAA privacy rules. This authorization should be considered a HIPAA authorization for release of health information. I hereby authorize the disclosure of information relating to my coverage under the Plan to the extent necessary for the completion of this form. I understand that after this information is disclosed, federal law might not protect the information. Further, I understand that I have the right to revoke this authorization at any time in writing and that the revocation is only effective after it is received and the revocation will have no effect if it is received after the requested information is released. This authorization will expire on the date the completed form is forwarded to the Chicago Regional Council of Carpenters Welfare Fund. I acknowledge that I am voluntarily signing this form to release my health information directly to the Chicago Regional Council of Carpenters Welfare Fund.

Covered Individual Signature: _____ Date Signed: _____

Covered Individual ID# (from your current health plan ID card): _____

(TURN OVER)

INS CONT COVER

Receipt of this form does not guaranty eligibility.

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
RETIREE PLAN OF BENEFITS
12 East Erie Street, Chicago, IL 60611
Telephone: (312) 787-9455 – Option 4
Facsimile: (312) 951-3986
Email: pension@crccbenefits.org

PAGE 2 of 2 -- Continuous Coverage Verification Form for Enrollment in the Retiree Health Care Benefits

Retired Carpenter's Name:	Retired Carpenter's SSN# or UID#:

This page of the form must be completed by the other Health Plan or the Employer and returned directly to the Retiree Plan by either mail, facsimile or email. The Plan's contact information appears above.
Please print clearly.

Name of Health Plan (ex: BCBS, Aetna, etc.):				Health Plan ID & Covered Individual ID Number:				
Name of Employer (If Employer Sponsored Plan):								
Health Plan Address and Telephone Number:								
Name of Covered Individual and Each Dependent **(Please List Each Individual Separately)**:	Date Hospital/ Medical Coverage Began:	Date Hospital/ Medical Coverage Ended or Will End:	Date Prescription Drug Coverage Began:	Date Prescription Drug Coverage Ended or Will End:	Date Dental Coverage Began:	Date Dental Coverage Ended or Will End:	Date Vision Coverage Began:	Date Vision Coverage Ended or Will End:
Printed Name of Individual Completing This Form:			Title:		Telephone Number:			
Signature of Individual Completing this Form:					Date Form Completed/Signed:			

Receipt of this form does not guaranty eligibility.