



CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND

12 EAST ERIE STREET • CHICAGO, IL 60611

(312) 787-9455, OPTION 3

FAX: 312-951-1515



Your Future — Our Focus

Participant Information Form

Instructions: **Print Clearly in Ink.** You must complete the form in full, sign and return it to the Fund Office along with your **original marriage certificate** and an **original certified birth certificate for your dependent(s)** new to the plan. Original documentation will be returned to you. **Failure to complete this form in full** will result in the form being returned to you and will delay payment of claims.

<input type="checkbox"/> Initial or Annual PIF		<input type="checkbox"/> Add Dependent(s) (marriage, birth, new step-kids, etc.)		<input type="checkbox"/> Drop Dependent(s) (divorce, etc.)	
Part 1 – Participant Information					
1. Participant's Last Name		First	Middle Initial	2. Soc. Sec. 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. Date of Birth: / /		9. Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
10. Marital Status: (Please check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed					
11. Telephone Number: ()			12. Cell Phone Number: ()		
13. Email Address:			14. Are you on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare Claim/Tricare Card Number (HIC):		
Part 2 – Spouse Information					
1. Spouse's Last Name		First	Middle Initial	2. Soc. Sec. Number or Individual Tax ID Number (ITIN) (Mandatory):	
3. Date of Birth / /		4. Telephone Number: ()		5. Are you on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):	
6. Is Spouse Employed?: <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Name of Employer:				7. Employers Telephone Number ()	
8. Employer's Address			9. City	10. State	11. Zip Code
Part 3 – Dependent Children Information. Complete all information or the form will be returned to you as incomplete.					
1a. Child's Last Name		First	Middle Initial	1b. Child's Date of Birth / /	1c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
1d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step Child <input type="checkbox"/> Other -Explain:		1e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: City: State:		1f. Child's Soc. Sec. Number (Mandatory)	1g. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):
2a. Child's Last Name		First	Middle Initial	2b. Child's Date of Birth / /	2c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
2d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step Child <input type="checkbox"/> Other -Explain:		2e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: City: State:		2f. Child's Soc. Sec. Number (Mandatory)	2g. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):
3a. Child's Last Name		First	Middle Initial	3b. Child's Date of Birth / /	3c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
3d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step Child <input type="checkbox"/> Other -Explain:		3e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: City: State:		3f. Child's Soc. Sec. Number (Mandatory)	3g. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):
5. Do you need to list more dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list them on the attached and return with this form.					
Part 4 – Other Insurance Information					
1. Are you, your Spouse or Dependent Children insured under any other Plan? <input type="checkbox"/> Hospital/Medical, <input type="checkbox"/> Prescription, <input type="checkbox"/> Dental or <input type="checkbox"/> Vision: <input type="checkbox"/> No			2. If yes, Name of Insurance Carrier:		
3. Policy Number:		4. Insurance Carrier's Phone Number: ()		5. Family members insured under the Other Insurance Policy (check all that apply): <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> All Children <input type="checkbox"/> Child List name(s):	
PLEASE SEND A COPY OF THE FRONT & BACK OF OTHER INSURANCE AND/OR MEDICARE CARD WHEN YOU RETURN THIS FORM					
Statement: 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 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. Receipt or completion of this form is not a guarantee of eligibility.					
X _____ Participant's Signature			X _____ Spouse's Signature		
Date			Date		

Part 3 Continued – Dependent Children Information. Complete all information or the form will be returned to you as incomplete.

4a. Child's Last Name First Middle Initial			4b. Child's Date of Birth / /		4c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		4d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step Child <input type="checkbox"/> Other -Explain:	
4e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: City: State:				4f. Child's Soc. Sec. Number (Mandatory)		4g. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
5a. Child's Last Name First Middle Initial			5b. Child's Date of Birth / /		5c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		5d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step Child <input type="checkbox"/> Other -Explain:	
5e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: City: State:				5f. Child's Soc. Sec. Number (Mandatory)		5g. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
6a. Child's Last Name First Middle Initial			6b. Child's Date of Birth / /		6c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		6d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step Child <input type="checkbox"/> Other -Explain:	
6e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: City: State:				6f. Child's Soc. Sec. Number (Mandatory)		6g. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
7a. Child's Last Name First Middle Initial			7b. Child's Date of Birth / /		7c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		7d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step Child <input type="checkbox"/> Other -Explain:	
7e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: City: State:				7f. Child's Soc. Sec. Number (Mandatory)		7g. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
8a. Child's Last Name First Middle Initial			8b. Child's Date of Birth / /		8c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		8d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step Child <input type="checkbox"/> Other -Explain:	
8e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: City: State:				8f. Child's Soc. Sec. Number (Mandatory)		8g. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
9a. Child's Last Name First Middle Initial			9b. Child's Date of Birth / /		9c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		9d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step Child <input type="checkbox"/> Other -Explain:	
9e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: City: State:				9f. Child's Soc. Sec. Number (Mandatory)		9g. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		
10a. Child's Last Name First Middle Initial			10b. Child's Date of Birth / /		10c. Child's Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		10d. Relationship to Participant: <input type="checkbox"/> Son <input type="checkbox"/> Daughter <input type="checkbox"/> Step Child <input type="checkbox"/> Other -Explain:	
10e. Does the above named child live at same address as Participant: <input type="checkbox"/> Yes <input type="checkbox"/> No If no, list address: City: State:				10f. Child's Soc. Sec. Number (Mandatory)		10g. Is Child on Medicare or Tricare? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide Medicare/Tricare Card Number (HIC):		