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

* P I F *

**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.

☐ Initial or Annual PIF ☐ Add Dependent(s) (marriage, birth, new step-kids, etc.) ☐ 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: ☐ Male ☐ Female | 10. Marital Status: (Please check one) ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed |
| 11. Telephone Number: ( ) | 12. Cell Phone Number: ( ) | |
| 13. Email Address: | 14. Are you on Medicare or Tricare? ☐ Yes ☐ 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? ☐ Yes ☐ No If yes, provide Medicare/Tricare Card Number (HIC): |
| 6. Is Spouse Employed?: ☐ Yes ☐ 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: ☐ Male ☐ Female | 1d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Step Child ☐ Other -Explain: |
| 1e. Does the above named child live at same address as Participant: ☐ Yes ☐ No If no, list address: City: State: | 1f. Child's Soc. Sec. Number (Mandatory) | 1g. Is Child on Medicare or Tricare? ☐ Yes ☐ 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: ☐ Male ☐ Female | 2d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Step Child ☐ Other -Explain: |
| 2e. Does the above named child live at same address as Participant: ☐ Yes ☐ No If no, list address: City: State: | 2f. Child's Soc. Sec. Number (Mandatory) | 2g. Is Child on Medicare or Tricare? ☐ Yes ☐ 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: ☐ Male ☐ Female | 3d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Step Child ☐ Other -Explain: |
| 3e. Does the above named child live at same address as Participant: ☐ Yes ☐ No If no, list address: City: State: | 3f. Child's Soc. Sec. Number (Mandatory) | 3g. Is Child on Medicare or Tricare? ☐ Yes ☐ No If yes, provide Medicare/Tricare Card Number (HIC): | |

5. Do you need to list more dependents? ☐ Yes ☐ 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? ☐ Hospital/Medical, ☐ Prescription, ☐ Dental or ☐ Vision: ☐ 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): ☐ Self ☐ Spouse ☐ All Children ☐ 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 Date

X _____ Spouse's Signature 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: □ Male □ Female | 4d. Relationship to Participant: □ Son □ Daughter □ Step Child □ Other -Explain: |
| 4e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State: | 4f. Child's Soc. Sec. Number (Mandatory) | | 4g. Is Child on Medicare or Tricare? □ Yes □ 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: □ Male □ Female | 5d. Relationship to Participant: □ Son □ Daughter □ Step Child □ Other -Explain: |
| 5e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State: | 5f. Child's Soc. Sec. Number (Mandatory) | | 5g. Is Child on Medicare or Tricare? □ Yes □ 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: □ Male □ Female | 6d. Relationship to Participant: □ Son □ Daughter □ Step Child □ Other -Explain: |
| 6e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State: | 6f. Child's Soc. Sec. Number (Mandatory) | | 6g. Is Child on Medicare or Tricare? □ Yes □ 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: □ Male □ Female | 7d. Relationship to Participant: □ Son □ Daughter □ Step Child □ Other -Explain: |
| 7e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State: | 7f. Child's Soc. Sec. Number (Mandatory) | | 7g. Is Child on Medicare or Tricare? □ Yes □ 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: □ Male □ Female | 8d. Relationship to Participant: □ Son □ Daughter □ Step Child □ Other -Explain: |
| 8e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State: | 8f. Child's Soc. Sec. Number (Mandatory) | | 8g. Is Child on Medicare or Tricare? □ Yes □ 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: □ Male □ Female | 9d. Relationship to Participant: □ Son □ Daughter □ Step Child □ Other -Explain: |
| 9e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State: | 9f. Child's Soc. Sec. Number (Mandatory) | | 9g. Is Child on Medicare or Tricare? □ Yes □ 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: □ Male □ Female | 10d. Relationship to Participant: □ Son □ Daughter □ Step Child □ Other -Explain: |
| 10e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State: | 10f. Child's Soc. Sec. Number (Mandatory) | | 10g. Is Child on Medicare or Tricare? □ Yes □ No If yes, provide Medicare/Tricare Card Number (HIC): |