

CENTRAL ILLINOIS CARPENTERS  
HEALTH AND WELFARE TRUST FUND  
200 S. MADIGAN DRIVE  
LINCOLN, IL 62656  
PH: (217-) 732-1919 FAX (217) 732-7799

Annual Enrollment Form

**MEMBER INFORMATION**

_____	_____	_____	_____
(Last Name)	(First Name)	(MI)	(Local Number)
_____			_____
(Street Address)			(Social Security Number)
_____	_____	_____	_____
(City)	(State)	(Zip Code)	(Date of Birth)
_____			<input type="checkbox"/> Male or <input type="checkbox"/> Female
(Area Code)	(Phone Number)		

**Marital Status:**  Single  Married  Divorced  Separated  Legally Separated  Widowed

**\*Spouse Name:** \_\_\_\_\_  
\*Attach copy of your Marriage Certificate (Date of Birth) (Social Security Number)

**Is Spouse Employed?**  Yes or  No **If yes, provide Employer information below:**

_____	_____
(Employer)	(Area Code) (Phone Number)
_____	
(Street Address)	(City) (State) (Zip Code)

**Does Spouse have Insurance Coverage?**  Yes or  No **If yes, provide Plan information below:**

_____	_____	_____
(Insurance Name)	(Group/ID No.)	(Area Code) (Phone Number)
_____		
(Street Address)	(City)	(State) (Zip Code)

**Coverage Type:**  Medical  Dental  Ortho  Vision **Plan Type:**  Family  Individual  
(Please check all that apply)

**Are you or any dependent other than your spouse covered under another insurance plan?**  Yes or  No **If yes, provide Plan information below:**

_____	_____	_____
(Insurance Name)	(Group/ID No.)	(Area Code) (Phone Number)
_____		
(Street Address)	(City)	(State) (Zip Code)

**Beneficiary Information**  
Schedule of Benefits I - Only

**Primary Beneficiary** (if applicable) \_\_\_\_\_ (Relationship)

\_\_\_\_\_ (Street Address) (City) (State) (Zip Code)

**Secondary Beneficiary** (if applicable) \_\_\_\_\_ (Relationship)

(If Primary Beneficiary is deceased, Death benefit is paid to Secondary Beneficiary)

\_\_\_\_\_ (Street Address) (City) (State) (Zip Code)

**CONTINUE COMPLETION OF THIS FORM ON REVERSE SIDE → →**

**Dependent Child Information**  
(Any Missing Information May Delay Claim Processing)

List ALL dependent children, unmarried, under age 19 (or under age 23 if a full-time student) \*Relationship to you (Natural Child, stepchild or other, please specify). Please refer to the Summary Plan Description (your booklet) for definitions of a Covered Dependent Child. Attach a separate sheet of paper for additional dependents or information. Verification of full-time student status is needed for children age 19-23 years.

Full Legal Name (Last Name, First Name, MI)	Relationship*	Social Security Number	Date of Birth	Sex

\*\*\*Note: For any child listed above not born of your current marriage, please complete the information for each dependent\*\*\*

1. Complete the information below for any child not born of your current marriage. **Send a copy** of the natural parent's **Divorce Decree** which is necessary for Central Illinois Carpenters Health and Welfare Trust Fund (CICHWTF) to determine your legal responsibility to provide medical coverage.

Complete the information below for any child who is your natural child not born of a valid marriage and who does not reside with you. Please submit a copy of the Court Decree (QMSCO) relating to medical, dental and vision expense responsibility. If your natural child was born prior to marriage, submit a birth certificate.

(a) \_\_\_\_\_ (b) \_\_\_\_\_  
 (Child's Name) (Relationship to CICHWTF Employee)

(c) \_\_\_\_\_  
 (Natural's Mother's Last Name (First Name) (MI)  
 if not a CICHWTF Participant)

\_\_\_\_\_  
 (Street Address) (City) (State) (Zip Code)

\_\_\_\_\_  
 (Date of Birth) (Social Security Number)

\_\_\_\_\_  
 (Insurance Company) (Policy Number)

\_\_\_\_\_  
 (Insurance Company Address)

(d) \_\_\_\_\_  
 (Natural's Father's Last Name (First Name) (MI)  
 if not a CICHWTF Participant)

\_\_\_\_\_  
 (Street Address) (City) (State) (Zip Code)

\_\_\_\_\_  
 (Date of Birth) (Social Security Number)

\_\_\_\_\_  
 (Insurance Company) (Policy Number)

\_\_\_\_\_  
 (Insurance Company Address)

(e) \_\_\_\_\_  
 (Name of Parent with Custody)

\*\*\*Note: If an ex-spouse has remarried, CICHWTF may request information concerning other coverage\*\*\*

I authorize any physician, hospital, insurer, or other organization or person having any records, data, or information concerning me or my minor dependents to furnish such records, data, or information as may be requested by such company to this Fund or their duly authorized representative. I understand my rights pursuant to the Health Insurance Portability and Accountability Act, and that, specifically, I waive the right for such information to be privileged by executing this authorization. A photocopy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
 (Signature of Employee)

\_\_\_\_\_  
 (Date)