

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

**For Office Use Only**

Date Entered \_\_\_\_\_ By \_\_\_\_\_  
Special Handling \_\_\_\_\_  
USSI Notes \_\_\_\_\_  
COB Setup \_\_\_\_\_  
COBRA Notice \_\_\_\_\_

Health Plan Verification Form

\*\*\*THE SIGNED ORIGINAL OF THIS FORM IS REQUIRED\*\*\*

**MEMBER INFORMATION**

\_\_\_\_\_  
(Last Name) (First Name) (MI) (Local Number)  
\_\_\_\_\_  
(Street Address) (Social Security Number)  
\_\_\_\_\_  
(City) (State) (Zip Code) (Date of Birth)  
\_\_\_\_\_  
(Area Code) (Phone Number)  Male or  Female

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

**Marriage Certificate is required when adding a new spouse, Divorce Decree is required when removing a spouse, Birth Certificate is required when adding a new dependent.**

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

**Is Spouse Employed?**  Yes or  No

**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)

**Spouse's Other Insurance Coverage Type:** 1)  Medical  Dental 3) **Plan Type Coverage**  Family  Individual  
(Please check all that apply) 2)  HMO  PPO

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

\_\_\_\_\_  
(Dependent's Name)  
\_\_\_\_\_  
(Insurance Name) (Group/ID No.) (Area Code) (Phone Number)  
\_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

**Life Insurance Benefit Beneficiary Information**  
Schedule of Benefits I - Only

\_\_\_\_\_  
**Primary Beneficiary** (Relationship)  
\_\_\_\_\_  
(Street Address) (City) (State) (Zip Code)

\_\_\_\_\_  
**Secondary Beneficiary** (if applicable) (Relationship)  
(If Primary Beneficiary is deceased, 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 under age 26 and relationship to you (natural child, stepchild or other, please specify) that you are requesting to be covered by you. **Please note: dependent children, ages 19-25, who were not added in a timely manner during the Special Enrollment period as of January 2011, can only be added within 30 days of a qualifying event. Please contact the Fund Office for more information.**

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) (Insurance Company Address) (Policy Number)

(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) (Insurance Company Address) (Policy Number)

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

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 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.

**Any person who knowingly, and with intent to defraud the Fund or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, will be committing a fraudulent insurance act, which is a crime.**

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

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