PHONE (715) 835-3174
TOLL FREE - 1-800-424-3405 (Nationwide)

NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND

P.O. BOX 4002 ★ EAU CLAIRE, WISCONSIN 54702

Dear Participant:

Completing the "Family Information Form" provides the Health Fund with important information needed to process claims on you and your Dependents. To help us keep your records up to date, **we require Participants to complete this family form once a year even though you may not have changes.** If changes do occur after you return this form, call the Fund Office and we will send you another family form to update those changes.

To avoid a delay in the processing of your claims, be sure to answer **all** the questions completely, sign and date the bottom and return this form promptly to:

NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND
PO BOX 4002
EAU CLAIRE, WI 54702-4002

Sincerely,

BOARD OF TRUSTEES

NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND
FAMILY INFORMATION FORM

PLEASE COMPLETE AND RETURN EVEN IF NO CHANGES HAVE TAKEN PLACE (PLEASE PRINT)

PARTICIPANT NAME (LAST, FIRST, M.I.) SOC. SEC. NO.

ADDRESS CITY/STATE/ZIP

TELEPHONE NO. ( ) BIRTH DATE SEX ☐F ☐M

PARTICIPANT'S MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

DATE OF MARRIAGE (IF APPLICABLE) DATE OF DIVORCE (IF APPLICABLE)
DATE OF LEGAL SEPARATION (IF APPLICABLE)

DO YOU HAVE MEDICARE COVERAGE? ☐ YES ☐ NO IF YES, EFFECTIVE DATE:_____

SPOUSE'S NAME (LAST, FIRST, M.I.) BIRTH DATE SEX ☐F ☐M

SPOUSE'S ADDRESS CITY/STATE/ZIP COUNTRY POSTAL CODE

SPOUSE'S SOC. SEC. NO. SPOUSE'S EMPLOYER

DOES YOUR SPOUSE HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE BELOW.

NAME AND ADDRESS OF OTHER INSURANCE COMPANY

GROUP NAME GROUP NO.

INSURED'S I.D. OR SOC. SEC. NO. EFFECTIVE DATE

TYPE OF COVERAGE ☐ FAMILY OR ☐ SINGLE PLEASE CHECK ALL BOXES THAT APPLY ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION DRUG

DOES YOUR SPOUSE HAVE MEDICARE COVERAGE? ☐ YES ☐ NO IF YES, EFFECTIVE DATE:_____

OTHER DEPENDENTS (NEW LAWS REQUIRE THE HEALTH FUND TO OBTAIN SOCIAL SECURITY NUMBERS ON ALL DEPENDENTS)

FIRST NAME	M.I.	LAST NAME (IF DIFFERENT)	SOC. SEC. NO.	DATE OF BIRTH	SEX	RELATIONSHIP TO PARTICIPANT	MEDICARE ELIGIBLE?
							☐Y ☐N
							☐Y ☐N
							☐Y ☐N
							☐Y ☐N

ARE YOU OR OTHER DEPENDENTS INSURED UNDER ANY OTHER HEALTH INSURANCE DIFFERENT FROM THE COVERAGE LISTED UNDER "SPOUSE INFORMATION"?
IF YES, PLEASE COMPLETE BELOW. ☐ YES ☐ NO ☐ FAMILY OR ☐ SINGLE ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION DRUG

POLICY HOLDER'S NAME BIRTH DATE

WHO IS COVERED UNDER THIS POLICY?

NAME AND ADDRESS OF OTHER INSURANCE COMPANY EFFECTIVE DATE

GROUP NAME GROUP NO. POLICY I.D. OR SOC. SEC. NO.

RELATIONSHIP TO YOU AND/OR YOUR DEPENDENT

I hereby certify the statements hereon and attached are complete and accurate, and I authorize any person or institution rendering care, or any person or organization in possession of insurance or other benefit information concerning me or my dependents, to furnish and disclose all known facts and data concerning disability to the North Central States Regional Council of Carpenters' Health Fund as well as to any cost containment organizations and entities retained by or authorized by the Trustees.

SIGNATURE _____ DATE _____