Your Future — Our Focus

Mid-America Carpenters Regional Council Health Fund

Instructions for Completing an Adding a Dependent Form

USE THIS FORM TO:

1. Enroll a spouse.
2. Enroll dependent children or step-children.

WHO IS AN ELIGIBLE DEPENDENT AND WHAT DOCUMENTS YOU MUST SUBMIT

1. Your **lawful spouse**, as recognized under applicable state law and in a manner consistent with governing federal law and for whom all required documentation is submitted, if not legally separated or divorced from you.
2. Your **biological child** through the end of the calendar month in which he/she attains age 26. Or your child who is named as a dependent under a Qualified Medical Child Support Order or National Medical Support Order.
3. Your **adopted child** or a child placed in your home for legal adoption (before attaining the age of 18) through the end of the calendar month in which he/she attains age 26.
4. Your **biological or adopted child** with a physical or mental disability who is under the age of 26.
5. Your **unmarried stepchild** through the end of the calendar month in which he/she turns age 26, who is in a regular parent-child relationship with you, for whom you provide more than 50% of financial support for the calendar year and who lives with you for more than one-half of the calendar year.

Dependent	Examples of Proof of Dependent Status
Spouse	• Original or county certified marriage certificate
Child	• Original or certified birth certificate
Child for whom court order mandates coverage	• Original or certified Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice • Original or certified divorce decree (if the parents are divorced).
Adopted Child	• Interim order of placement and/or final adoption order
Stepchild	• Original or certified birth certificate • Divorce decree (if the parents are divorced) or a stepchild dependent affidavit or a death certificate of the biological parent.

TO COMPLETE THIS FORM:

1. Make certain to complete the form in its entirety.
2. Include the dependent's social security number (SSN) or Individual Tax Identification Number (ITIN).
3. If other insurance coverage exists, a copy of the other insurance card is required.
4. The form must be signed by the employee and spouse, if applicable.
5. Return the completed form, along with all required proof of dependent status to:

Mid-America Carpenters Regional Council Health Fund Office
Health Benefits Department
12 E. Erie Street
Chicago, IL 60611
Fax: 312-951-1515
activeenrollment@crccbenefits.org

For questions, call the Health Benefits Department at (312) 787-9455, option 3. Participant Service Representatives are available Monday thru Friday between the hours of 8:00 a.m. and 4:30 p.m.

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MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND

12 EAST ERIE STREET • CHICAGO, IL 60611
(312) 787-9455, PHONE OPTION 3
FAX: 312-951-1515
EMAIL: activeenrollment@crccbenefits.org

Dependent Add 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. See your Summary Plan Description for document requirements. Original documentation will be returned to you. Failure to complete this form in full will result in the form being returned to you.

Part 1 - Participant Information			
Last Name:	First:		Middle:
Date of birth:	SSN/ITIN:	BCBS UID No.	Phone Number:
Current address:			
City:	State:		ZIP Code:
Email address:			Cell Phone:

Part 2 - Spouse Information (A county-certified original marriage certificate is required to add your spouse)		
Spouse's Last Name:	First:	Middle
Current address:		
City:	State:	Zip:
SSN/ITIN (Required)	Gender:	Date of Birth:
Is Spouse Employed? ☐ Yes or ☐ No	If so, Employer Name and Address:	

Part 3 - Other Insurance information (copy of the front and back of the other insurance card is required)		
Name of Other Insurance:	Type of coverage: ☐ Group ☐ Medicare ☐ Tricare ☐ Public Aid ☐ Individual ☐ Supplemental ☐ Champus ☐ Student	
Coverage is: ☐ Individual or ☐ Family	Policy Number:	Group Number
Plan Type: ☐ HMO ☐ PPO ☐ POS ☐ Other (explain)	Name of Subscriber:	
	Effective Date:	Phone Number:

Part 4 - Dependent Information (Original birth certificate required to add any dependent. Additional requirements apply for step-children)			
Dependent's Last Name:	First:		Middle:
Does the Dependent Reside with you? ☐ Yes ☐ No. If no, provide address.			Phone:
City:		State:	ZIP Code:
Relationship: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other. If other, please specify:			Social Security Number: (Mandatory

Dependent 2		
Dependent's Last Name:	First:	Middle:
Does the Dependent Reside with you? ☐ Yes ☐ No. If no, provide address.		Phone:
City:	State:	ZIP Code:
Relationship: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other. If other, please specify:		Social Security Number:

Dependent 3		
Dependent's Last Name:	First:	Middle:
Does the Dependent Reside with you? ☐ Yes ☐ No. If no, provide address.		Phone:
City:	State:	ZIP Code:
Relationship: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other. If other, please specify:		Social Security Number:

Dependent 4		
Dependent's Last Name:	First:	Middle:
Does the Dependent Reside with you? ☐ Yes ☐ No. If no, provide address.		Phone:
City:	State:	ZIP Code:
Relationship: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other. If other, please specify:		Social Security Number:

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 Mid-America Carpenters Regional Council Health 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_____ **X**_____

Participant's Signature Date Spouse's Signature Date