MID-AMERICA CARPENTERS REGIONAL COUNCIL HEALTH FUND
12 E Erie St, Chicago, IL 60611 • (312) 787-9455, option 3 • FAX: (312) 951-1515
activeenrollment@carpenterbenefits.org

Your Future — Our Focus

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PARTICIPANT INFORMATION FORM

Complete this form in full, sign and return it to the Fund Office along with your marriage certificate if you are married and a **certified birth certificate** for each **dependent** new to the plan. **Please DO NOT send originals. Failure to complete this form in full** will result in the form being returned to you and will delay payment of claims. You must list ALL of the covered dependents in your family. Anyone you omit will be dropped from the Plan.

PART 1 – PARTICIPANT INFORMATION

***Print Clearly in black or blue ink**

1. Participant's Last Name	First	Middle Init.	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? ☐ No ☐ Yes If yes, provide Medicare Claim/Tricare Card Number (HIC):		

PART 2 – SPOUSE INFORMATION

1. Spouse's Last Name	First	Middle Init.	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? ☐ No ☐ Yes 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 – OTHER INSURANCE INFORMATION

***REQUIRED: include copies of other insurance cards**

1. Are you, your Spouse or Dependent Children insured under any other Plan? ☐ No ☐ Hospital/Medical, ☐ Prescription, ☐ Dental or ☐ Vision		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):

PART 4 – DEPENDENT INFORMATION

Complete **all information below for every Dependent** or this form will considered incomplete. Dependents not listed will be dropped from the Plan.

1a. Dependent's Last Name	First	Middle Initial	1b. Date of Birth / /	1c. Gender: ☐ Male ☐ Female	1d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other -Explain:
1e. Does the above named Dependent live at same address as Participant: □ Yes □ No If no, list address: City: State:			1f. Soc. Sec. Number (Mandatory)		1g. Is Dependent on Medicare or Tricare? ☐ No ☐ Yes If yes, provide Medicare/Tricare Card Number (HIC):
2a. Dependent's Last Name	First	Middle Initial	2b. Date of Birth / /	2c. Gender: ☐ Male ☐ Female	2d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other -Explain:
2e. Does the above named Dependent live at same address as Participant: □ Yes □ No If no, list address: City: State:			2f. Soc. Sec. Number (Mandatory)		2g. Is Dependent on Medicare or Tricare? ☐ No ☐ Yes If yes, provide Medicare/Tricare Card Number (HIC):
3a. Dependent's Last Name	First	Middle Initial	3b. Date of Birth / /	3c. Gender: ☐ Male ☐ Female	3d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other -Explain:
3e. Does the above named Dependent live at same address as Participant: □ Yes □ No If no, list address: City: State:			3f. Soc. Sec. Number (Mandatory)		3g. Is Dependent on Medicare or Tricare? ☐ No ☐ Yes If yes, provide Medicare/Tricare Card Number (HIC):

If you have more than three (3) Dependents, continue on page 2.

PART 4 – DEPENDENT INFORMATION CONT.

Complete **all information below for every Dependent** or this form will considered incomplete. Dependents not listed will be dropped from the Plan.

4a. Dependent's Last Name First Middle Initial	4b. Date of Birth / /	4c. Gender: ☐ Male ☐ Female	4d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other -Explain:
4e. Does the above named Dependent live at same address as Participant: □ Yes □ No If no, list address: City: State:	4f. Soc. Sec. Number (Mandatory)		4g. Is Dependent on Medicare or Tricare? ☐ No ☐ Yes If yes, provide Medicare/Tricare Card Number (HIC):
5a. Dependent's Last Name First Middle Initial	5b. Date of Birth / /	5c. Gender: ☐ Male ☐ Female	5d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other -Explain:
5e. Does the above named Dependent live at same address as Participant: □ Yes □ No If no, list address: City: State:	5f. Soc. Sec. Number (Mandatory)		5g. Is Dependent on Medicare or Tricare? ☐ No ☐ Yes If yes, provide Medicare/Tricare Card Number (HIC):
6a. Dependent's Last Name First Middle Initial	6b. Date of Birth / /	6c. Gender: ☐ Male ☐ Female	6d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other -Explain:
6e. Does the above named Dependent live at same address as Participant: □ Yes □ No If no, list address: City: State:	6f. Soc. Sec. Number (Mandatory)		6g. Is Dependent on Medicare or Tricare? □ No □ Yes If yes, provide Medicare/Tricare Card Number (HIC):
7a. Dependent's Last Name First Middle Initial	7b. Date of Birth / /	7c. Gender: ☐ Male ☐ Female	7d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other -Explain:
7e. Does the above named Dependent live at same address as Participant: □ Yes □ No If no, list address: City: State:	7f. Soc. Sec. Number (Mandatory)		7g. Is Dependent on Medicare or Tricare? ☐ No ☐ Yes If yes, provide Medicare/Tricare Card Number (HIC):
8a. Dependent's Last Name First Middle Initial	8b. Date of Birth / /	8c. Gender: ☐ Male ☐ Female	3d. Relationship to Participant: ☐ Son ☐ Daughter ☐ Stepchild ☐ Other -Explain:
8e. Does the above named Dependent live at same address as Participant: □ Yes □ No If no, list address: City: State:	8f. Soc. Sec. Number (Mandatory)		8g. Is Dependent on Medicare or Tricare? ☐ No ☐ Yes If yes, provide Medicare/Tricare Card Number (HIC):

If you have more than eight (8) Dependents, continue on a separate sheet.

By providing the information contained in this form, I understand and authorize the Health Fund, its representatives, or its third-party service providers to contact me by telephone, cellular phone, e-mail, or mail, for purposes of Health Fund administration and healthcare related activities such as enrollment and medical management. I consent and agree that the Health Fund and its third-party service providers may, from time to time in their sole discretion, make calls or send text messages to me using prerecorded messages or artificial voice or through the use of an automatic telephone dialing system to any phone number provided on this form, including to my cellular phone that could result in charges to me. I understand I may revoke my consent to receive such calls or messages sent to my cellular phone at any time.

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 _____
Participant Signature Date

X _____
Spouse Signature Date

BEFORE YOU SUBMIT YOUR APPLICATION, please check the following:

- ☐ I have double-checked each and every Section to ensure that all information is complete.
- ☐ I, my spouse, or my Dependent(s) have Other Insurance, so I have enclosed/attached copies of the front and back of their applicable insurance cards.

Return your completed application along with any required documentation via the method most convenient for you:

MAIL or DROP-OFF: 12 E. Erie, St., Chicago, IL 60611 or 4979 Indiana Ave, Lisle, IL 60532 (see Office Hours below for Drop-off times)

EMAIL: activeenrollment@carpenterbenefits.org **FAX:** FAX: (312) 951-1515

QUESTIONS? Call the Fund Office at (312) 787-9455, option 3. Representatives are available Monday through Friday: 8:00 a.m. - 4:30 p.m.