The Connecticut Carpenters Health Fund
HEALTH BENEFIT CLAIM FORM

IMPORTANT: The Fund does not honor claims for work-related injuries.
Be sure ALL QUESTIONS are answered, or your claims will be delayed.

CLAIM FORM TO BE FULLY COMPLETED BY THE MEMBER

A. Name of Member_____I.D.number: _____
Last First Middle

B. Address_____
Street Address City State Zip Code

C. Date of Birth _____ Telephone #: _(_____)_____

Cell phone#: _(_____)_____

D. Marital Status ____Married ____Single ____Widowed ____Separated ____Divorced

E. Name of Spouse _____Spouse S.S. Number:_____

F. Date of Birth _____ Is your spouse employed? ____YES ____NO

G. Name of Employer:_____ Employer Address_____

Employer Telephone number:_(_____)_____

H. Does your spouse have MEDICAL insurance? ____YES____NO Effective Date _____
I. Does your spouse have PRESCRIPTION coverage? ____YES____NO Effective Date_____
J. Does your spouse have DENTAL insurance? ____YES____NO Effective Date_____

If Yes, Name of Company_____ If YES, Policy# _____

If Yes, list Dependents:_____

K. If spouse is no longer employed, give Name/Location of last employer.

_____Date last worked:_____

L. Are you eligible for Medicare? Part A Effective Date: _____ Part B Effective Date:_____

Is your spouse eligible for Medicare: Part A Effective Date: _____ Part B Effective Date:_____

M. List other dependents:

Name	Sex	Date of Birth	Relationship	over age 19?	Full time student yes/no	S.S. Number

***If child over age 19, full time student verification is required by the Fund for each semester.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE THE CARPENTERS FUND, FILES A STATEMENT OF CLAIM CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION MAY BE GUILTY OF A CRIMINAL ACT PUNISHABLE UNDER LAW.

Authorization to Release Information: I hereby authorize any individual or organization to release any information to the Connecticut Carpenters Health Fund for any treatment, services, or benefits received or payable to me or on my behalf.

_____ _____
Member's Signature Required Date Signed

RETURN THIS FORM TO:

Connecticut Carpenters Health Fund
10 Broadway
Hamden, CT 06518-2699

Tel#(203) 281-5511
Toll Free (800) 922-6026
Fax#(203) 288-3235

Website: www.ctcarpentersfunds.org