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 _____ Social Security number _____
Last First Middle

B. Address _____
Street Address City State Zip Code

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

D. Marital Status ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

E. Name of Spouse _____ Social Security number _____

F. Date of Birth _____ Is your spouse employed? ☐ YES ☐ NO

G. Name of Employer _____ Employer Address _____

Employer Telephone # _(_____) _____ _____

H. Does your spouse have MEDICAL insurance? ☐ YES ☐ NO

If YES, name of company _____ Policy #: _____

If YES, list covered dependents: _____

I. Does your spouse have DENTAL insurance? ☐ YES ☐ NO

If YES, name of company _____ Policy #: _____

If YES, list covered dependents: _____

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

_____ Date last worked? _____

K. 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: _____

L. List other dependents:

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

***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, Connecticut 06518-2699

Tel: (203)281-5511 or **800-922-6026**
Fax:(203)288-3235