

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 _____ 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: _____

Is member or spouse social security disabled? yes no.

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	S.S. Number

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.

**** AN ADULT DEPENDENT FORM IS REQUIRED IF YOUR DEPENDENT IS OVER AGE 19 AND UNDER AGE 26. ****

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