NORTH CENTRAL STATES REGIONAL COUNCIL OF CARPENTERS' HEALTH FUND
FAMILY INFORMATION FORM

PLEASE COMPLETE AND RETURN EVEN IF NO CHANGES HAVE TAKEN PLACE (PLEASE PRINT)

PARTICIPANT INFORMATION

NAME (LAST, FIRST, M.I.) SOC. SEC. NO.

ADDRESS CITY/STATE/ZIP

TELEPHONE NO. ( ) BIRTH DATE SEX ☐ F ☐ M

PARTICIPANT'S MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ LEGALLY SEPARATED

DATE OF MARRIAGE (IF APPLICABLE) DATE OF DIVORCE (IF APPLICABLE)

SPOUSE INFORMATION

SPOUSE'S NAME (LAST, FIRST, M.I.) BIRTH DATE

SPOUSE'S ADDRESS CITY/STATE/ZIP COUNTRY POSTAL CODE

SPOUSE'S SOC. SEC. NO. SPOUSE'S EMPLOYER

DOES YOUR SPOUSE HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO IF YES, PLEASE COMPLETE BELOW.

NAME AND ADDRESS OF OTHER INSURANCE COMPANY

GROUP NAME GROUP NO.

INSURED'S I.D. OR SOC. SEC. NO. EFFECTIVE DATE

TYPE OF COVERAGE ☐ FAMILY OR ☐ SINGLE PLEASE CHECK ALL BOXES THAT APPLY ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION DRUG

OTHER DEPENDENTS (NEW LAWS REQUIRE THE HEALTH FUND TO OBTAIN SOCIAL SECURITY NUMBERS ON ALL DEPENDENTS)

FIRST NAME M.I. LAST NAME (IF DIFFERENT)	SOC. SEC. NO.	DATE OF BIRTH	SEX	MARITAL STATUS	RELATIONSHIP TO PARTICIPANT

ARE YOU OR OTHER DEPENDENTS INSURED UNDER ANY OTHER HEALTH INSURANCE DIFFERENT FROM THE COVERAGE LISTED UNDER "SPOUSE INFORMATION"?
IF YES, PLEASE COMPLETE BELOW. ☐ YES ☐ NO ☐ FAMILY OR ☐ SINGLE ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ PRESCRIPTION DRUG

POLICY HOLDER'S NAME BIRTH DATE

WHO IS COVERED UNDER THIS POLICY?

NAME AND ADDRESS OF OTHER INSURANCE COMPANY EFFECTIVE DATE

GROUP NAME GROUP NO. POLICY I.D. OR SOC. SEC. NO.

RELATIONSHIP TO YOU AND/OR YOUR DEPENDENT

I hereby certify the statements hereon and attached are complete and accurate, and I authorize any person or institution rendering care, or any person or organization in possession o insurance or other benefit information concerning me or my dependents, to furnish and disclose all known facts and data to the North Central States Regional Council of Carpenters Health Fund as well as to any cost containment organizations and entities retained by or authorized by the Trustees.

SIGNATURE ______________________ DATE ______________