New England Carpenters Health Fund-Connecticut Office

HEALTH BENEFIT CLAIM FORM

2019

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_____
Mailing 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 Spouse's Employer: _____ Employer Address_____

Employer Telephone number :_(_____) _____

H. Does your spouse have other MEDICAL insurance? ____YES___NO Effective Date: _____
I. Does your spouse have other DENTAL insurance? ____YES___NO Effective Date: _____

If yes, Policy# _____ Company: _____
If yes, list Dependents that are covered under other insurance: _____

Is member or spouse Social Security disabled? _____ yes ____ no. If yes, Effective Date _____

J. Are you eligible for Medicare? ____ YES ____NO Part A Effective Date: _____ Part B Effective Date: _____

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

K. Does your **listed Dependent(s)** have other MEDICAL insurance? ____YES ___NO Effective Date: _____
L. Does your **listed Dependent(s)** have other DENTAL insurance? ____YES ___NO Effective Date: _____

If yes, name of Policy Holder: _____ Relationship: _____ Policy#_____ Company_____

M. List your dependents (eligible children covered up to age 26):

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.

Authorization to Release Information: I hereby authorize any individual or organization to release any information to the N.E. Carpenters Health Fund (CT Office) 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: New England Carpenters Health Fund (CT Office)
10 Broadway
Hamden, CT 06518-2699

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

Website: www.ctcarpentersfunds.org