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_____
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 and/or child(ren) have other MEDICAL insurance? ____YES___NO Effective Date: _____
I. Does your spouse and/or child(ren) have other PRESCRIPTION coverage? ____ YES___NO Effective Date: _____
J. Does your spouse and/or child(ren) have other DENTAL insurance? ____YES___NO Effective Date: _____

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

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

K. If spouse is no longer employed, give Name/Address 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 (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 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