

# 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 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 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