Instructions for Participant Enrollment
in the Chicago Regional Council of Carpenters Welfare Fund
Retiree Plan of Benefits Following a Postponement or Cancellation

1. **Complete the Enrollment Form and Participant Information Form (PIF) in their entirety**. Print clearly **in ink** and answer all questions. Enrollment will be delayed if the forms are not legible or if a question is left unanswered. (Note: If you have other insurance, you must make a copy of your insurance card and return it with the completed forms. This also applies for a spouse or dependent child that you are now enrolling in the Retiree Plan.)

2. **You, the carpenter, must sign and date the enrollment form. Both you and your spouse (if married) must sign the Participant Information Form.** The forms are not valid without signatures. The spouse must sign the PIF regardless of whether or not the spouse is enrolling in the Retiree Plan of Benefits at this time.

3. **If you are enrolling a dependent child you must also complete and return an "Enrollment Form for a Dependent Child."** This is a separate form that can be obtained from the Retirement Benefits Department.

4. **Submit the completed Enrollment Form and all required documents necessary for enrollment to**:

   Chicago Regional Council of Carpenters Welfare Fund
   Attn: Retirement Benefits Department
   12 East Erie Street – 8th Floor, Chicago, IL 60611

   Please consider the following:

   - If you previously postponed or cancelled coverage under the Retiree Plan, late enrollment will only be considered in circumstances where you (and any dependents you are now enrolling) have been continuously covered by another health plan.

   - You must enroll within ninety (90) days of the date coverage under the other health plan ended. Coverage under the Retiree Plan will begin on the first day of the month in which the other health care plan terminates. However, if the other health care plan terminates on the last day of the month, coverage under the Retiree Plan generally begins on the first day of the following month. You are responsible for payment of any required premium(s) for the full month during which coverage under the Retiree Plan begins.

   - You must submit **either** a Certificate of Creditable Coverage from the other health plan **OR** have the attached Continuous Coverage Verification form completed by the other health plan or employer. If you were covered under more than one other health plan during the postponement period, you will need to provide documentation for each of the health plans.

   - Coverage for a spouse or dependent child is contingent upon your eligibility as well the spouse or dependent child meeting the conditions for benefit coverage. Your spouse or dependent child can only be enrolled in the same type of coverage in which you are enrolled. For example, if you are only enrolled in the Prescription Drug benefit, then that is the only benefit in which you can enroll your spouse or dependent child.

Carefully review your coverage options and the Plan provisions before completing the enrollment form. The Summary Plan Description ("SPD") is available on the Fund's website at www.crccbenefits.org. On the home page, select "Benefit Info – Retiree." You will find a link to the SPD under the Eligibility & Enrollment tab. A SPD will automatically be mailed to you once the enrollment is processed. You may also contact the Retirement Benefits Department to request a hardcopy of the SPD.

FREQUENTLY ASKED QUESTIONS

Enrollment for Participants Following a Postponement or Cancellation

Retiree Plan of Benefits

1. When can I enroll in coverage?

Generally, you must enroll in coverage at the time your pension initially begins. However, if you postpone coverage or enroll in coverage but later cancel coverage, you may enroll in the Retiree Plan provided that you maintained continuous coverage with another health plan from the date of postponement (or cancellation) through the date of enrollment in the Retiree Plan. You must enroll in the Retiree Plan within 90 days of the date coverage under the other health plan ended.

2. What are the Plan's documentation requirements for enrollment?

- ✓ A fully completed and signed Enrollment Form
- ✓ A Participant Information Form (PIF)
- ✓ An original county certified birth certificate for you, the carpenter
- ✓ An original county certified birth certificate for your spouse (if you are enrolling your spouse)
- ✓ An original county certified marriage certificate for you and your spouse (if you are enrolling your spouse)
- ✓ Proof of continuous coverage from the other health plan (in the form of either a Certificate of Creditable Coverage OR the Retiree Plan's "Continuous Coverage Verification Form" (completed by the other health plan or the employer))

3. Does the Fund require original documentation for enrollment?

Yes. Original documents are required. However, after the Retirement Benefits Department images the documents, they will be returned to you via delivery confirmation through the U.S. Post Office.

4. How do I submit the required documents?

You may either hand-deliver or mail original documents to the Fund Office at: Chicago Regional Council of Carpenters Welfare Fund, Attn: Retirement Benefits Department, 12 East Erie Street, 8th Floor, Chicago, IL 60611. The originals will be returned to you via delivery confirmation through the U.S. Post Office.

5. When must I submit the enrollment forms and the required documents?

The enrollment forms and all of the required supporting documents **must** be submitted to the Retirement Benefits Department within ninety (90) days of the date coverage under another health plan ends.

6. Will I receive verification that my enrollment was processed?

Yes, the Retirement Benefits Department will mail a confirmation to your home address after enrollment is complete.

7. Who can answer my questions about the enrollment requirements?

Any one of the Retirement Benefits Representatives can answer your questions. Call the Fund Office at 312-787-9455, telephone option 4, Monday through Friday, between 8:00 a.m. and 4:30 p.m.

9. Can I enroll my spouse who has insurance through his/her employer?

Yes, your spouse can be covered under this Plan and a second plan. However, the coverage available through your spouse's employer is the primary carrier and the Fund will pay second.

10. In what type of coverage may I enroll my spouse?

Your spouse can only be enrolled in the same type of coverage that you elect. For example, if you are only enrolled in the Prescription Drug benefit, then that is the only benefit in which you can enroll your spouse.

11. Do I need to pay a premium for coverage?

Yes. The premium for coverage will be deducted from your monthly pension payment. You are responsible for payment of any required premium(s) for the full month during which coverage under the Retiree Plan begins. In rare cases, the total monthly premium amount may be greater than the monthly pension amount. If this occurs, special arrangements will be made to allow you to submit payments for the difference in the amounts. If this applies to you, the Retirement Benefits Department will contact you regarding payment submission after all of the required enrollment materials are received.

12. What are the premiums for coverage?

Please refer to the attached Retiree Health Benefit Premium sheets. Be aware that all premiums may increase in the future.

Chicago Regional Council of Carpenters Welfare Fund

12 East Erie Street, Chicago, Illinois 60611 (312)787-9455, Menu Option #4

RETIREE HEALTH BENEFIT PREMIUMS

(Premiums Effective January 1, 2011)

For those who meet the eligibility requirements for Retiree Health Benefits, the Comprehensive Medical Benefit monthly premiums and the Prescription Drug Benefit monthly premiums will be determined by the number of years of Vesting Credit that a participant has earned. (A maximum of one year of Vesting Credit can be earned per calendar year.) Current Retiree Premiums appear in the following chart**. Note that these premiums may increase in the future.**

IMPORTANT:

- No coverage is provided under the Retiree Plan of Benefits for: life insurance; accidental death & dismemberment insurance; weekly sickness & accident disability benefits; or vision benefits.
- "Active" Carpenter Plan Deductibles and/or Out of Pocket Coinsurance Maximums do not carry over to the Retiree Plan.
- Retiree coverage does not include the ComPsych Network. Coverage for mental health/substance abuse is considered under the Comprehensive Medical Benefits, subject to the Retiree Plan's PPO & non-PPO deductibles and co-payments

Years of Vesting Credit	Per Person Per Month Premium for **Non-Medicare Eligible Comprehensive Medical Benefits**	Per Person Per Month Premium for **Medicare Eligible Comprehensive Secondary Medical Benefits**	Per Person Per Month Premium for **Prescription Drug Coverage**
10	300.00	80.00	106.00
11	294.00	77.00	106.00
12	289.00	76.00	106.00
13	284.00	75.00	106.00
14	278.00	74.00	106.00
15	273.00	72.00	96.00
16	267.00	70.00	96.00
17	262.00	69.00	96.00
18	257.00	67.00	96.00
19	251.00	65.00	96.00
20	246.00	64.00	86.00
21	241.00	62.00	86.00
22	235.00	61.00	86.00
23	230.00	59.00	86.00
24	225.00	57.00	86.00
25	219.00	56.00	75.00
26	214.00	55.00	75.00
27	209.00	52.00	75.00
28	203.00	51.00	75.00
29	198.00	50.00	75.00
30 or more	187.00	47.00	75.00

(OVER)

DISABILITY PENSIONERS – SPOUSE & DEPENDENT PREMIUMS

The monthly Retiree Health Care Benefit premium rate **for spouses and dependent children of pensioners receiving Disability pensions** are **not** based on the number of years of earned Vesting credit.

The current premiums are as follows and may increase in the future:

- $170.00 per person per month for Comprehensive Major Medical coverage
- $55.00 per person per month for prescription drug coverage

The premium charged for you, the disability pensioner, will still be determined in accordance with the tiered premium structure.

If your spouse or dependent child is now or later becomes eligible for Medicare, the premium for your spouse or dependent is or will be determined by the tiered premium structure.

DENTAL PLAN

(Premiums Effective April 1, 2017)

If an individual enrolls in dental coverage, has services, and then cancels coverage before being enrolled in dental coverage for at least one full year, the Trustees prohibit re-enrollment for a period of two years.

	Monthly Premium
One Individual Enrolled	$ 42.92
Two Individuals Enrolled	$ 83.30
Family (3 or more) Enrolled	$147.80

VISION PLAN

(Premiums Effective April 1, 2017)

If an individual enrolls in vison coverage, has services, and then cancels coverage before being enrolled in vison coverage for at least one full year, the Trustees prohibit re-enrollment for a period of two years.

	Monthly Premium
One Individual Enrolled	$ 6.16
Two Individuals Enrolled	$ 12.01
Family (3 or more) Enrolled	$17.99

COBRA OPTION

(Premiums Effective February 1, 2017)

Please note that the COBRA coverage option is only available to those who are still eligible for the Carpenter's Active Plan of Benefits at the time they retire.

If you are eligible for the Carpenter's Active Plan of Benefits at the time you retire, you have the option of continuing your Active Plan under the COBRA option. Generally, COBRA coverage runs for a maximum of 18 months or until an individual becomes eligible for Medicare. If you elect the COBRA option, the Retiree Plan of Benefits would not begin until the month after the COBRA coverage ends. If you do NOT elect the COBRA option, the Retiree Plan of Benefits would begin the month after your Active Plan benefits end.

	Individual Premium Per Month	**Family Premium Per Month**
Hospital, Surgical, Major Medical, Prescription, Hearing, Routine Physical, Dental and Vision Coverage	$548.00	$1,354.00
All above coverage except Vision and Dental Benefits	$493.00	$1,218.00

(OVER)

SURVIVING SPOUSE'S HEALTH BENEFIT CONVERSION

When the carpenter dies, continuation coverage under COBRA is offered to the surviving spouse. Continuation coverage under COBRA is the same coverage that the surviving spouse had before the carpenter died.

Continuation coverage under COBRA can include dental coverage if the surviving spouse was covered under the Dental Plan at the time of the carpenter's death. *From April 2017 through March 2018, continuation coverage under COBRA that includes the Dental Plan costs an additional $42.92 per month.*

After April 1, 2017, continuation coverage under COBRA can include vision coverage if the surviving spouse was covered under the Vision Plan at the time of the carpenter's death. *From April 2017 through March 2018, continuation coverage under COBRA that includes the Vision Plan costs an additional $6.16 per month.*

Note that premiums may increase in the future.

(Premiums Effective February 1, 2017)

Type of Coverage	Monthly Premium
Medicare Eligible Surviving Spouse with Comprehensive Medicare Supplement coverage, **including** Prescription Drug coverage	$246.00 per month
Medicare Eligible Surviving Spouse with Comprehensive Medicare Supplement coverage, **without** Prescription Drug coverage	$111.00 per month
Non- Medicare Eligible Surviving Spouse with Comprehensive Medical Benefit coverage, **including** Prescription Drug coverage	$628.00 per month
Non- Medicare Eligible Surviving Spouse with Comprehensive Medical Benefit coverage, **without** Prescription Drug coverage	$463.00 per month
Prescription Drug Coverage Only	$135.00 per month

Your Future — Our Focus

Chicago Regional Council of Carpenters
Welfare, Pension and Supplemental Retirement Funds

12 East Erie Street • Chicago, Illinois 60611
(312) 787-9455 • Kristina M. Guastaferri, Administrator
www.crccbenefits.org

NONDISCRIMINATION STATEMENT

The Chicago Regional Council of Carpenters Welfare Fund (the "Plan") complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The Plan provides language assistant services to persons whose primary language is not English, and free aids and services where necessary to people with disabilities to communicate effectively with us. If you need these services, contact the Fund Office.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Fund Office by mail, telephone or in person at: Chicago Regional Council of Carpenters Welfare Fund, Attn: Cindy Rivera, Civil Rights Coordinator, 12 E. Erie Street, Chicago, IL 60611, Phone: 312-787-9455.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

* * *

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-312-787-9455.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-312-787-9455.

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-312-787-9455.

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-312-787-9455 (번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-312-787-9455.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-312-9455-787

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-312-787-9455.

સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-312-787-9455.

خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں 1-312-787-9455.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-312-787-9455.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-312-787-9455.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-312-787-9455 पर कॉल करें।

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-312-787-9455.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-312-787-9455.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-312-787-9455.

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND RETIREE PLAN OF BENEFITS
12 East Erie Street, Chicago, IL 60611
(312) 787-9455 – Option 4

* I N S M A I N T *

Enrollment Form for Retiree Health Care Benefits Following a Postponement or Cancellation

Instructions: **Print Clearly in Ink**. This 2 page form is used to enroll in the Retiree Healthcare Benefits following a postponement or cancellation of coverage by the carpenter. The retired carpenter must complete this form in full, sign and date it. Both pages of the completed form, a retiree Participant Information Form ("PIF") and all of the required supporting documentation must be submitted to the Retirement Benefits Department.

Carefully review your coverage options and the Plan provisions before completing this form. The Summary Plan Description ("SPD") is available on the Fund's website at www.crccbenefits.org. On the home page, select "Benefit Info – Retiree." You will find a link to the SPD under the Eligibility & Enrollment tab. A SPD will automatically be mailed to you during your first 30 days of eligibility under the Retiree Plan. You may also contact the Retirement Benefits Department to request a hardcopy of the SPD.

Important: You must enroll within ninety (90) days of the date coverage under the other health plan ended.

Participant's Name:		**Participant's SSN# or UID#** (UID# is on BCBS I.D. Card)	
Participant's Street Address, City, State & Zip:			**Participant's Date of Birth:**
Participant's E-Mail Address:		**Participant's Home Phone Number:**	**Participant's Cellular Phone Number:**
Spouse's Name:	**Date of Marriage:**	**Spouse's SSN:**	**Spouse's Date of Birth:**

Participant Coverage Election – You must submit an original county certified birth certificate.

Part A *Choose One*
- △ I am NOT currently Medicare Eligible
- △ I am currently Medicare Eligible (You must submit a copy of your Medicare card)

Part B *Choose One*
- O I elect to enroll in the Comprehensive Medical Benefits coverage
- O I do NOT wish to enroll in the Comprehensive Medical Benefits coverage
- O I am covered by an another comprehensive medical benefit plan and elect to postpone enrollment in the Welfare Fund's Comprehensive Medical Benefits coverage until coverage under the other plan ends.

Part C *Choose One*
- ☐ I elect to enroll in the Prescription Drug coverage
- ☐ I do NOT wish to enroll in the Prescription Drug coverage
- ☐ I am covered by another prescription drug plan and I elect to postpone enrollment in the Welfare Fund's Prescription Drug Coverage until coverage under the other plan ends.

Part D *Choose One*
- ◇ I elect to enroll in the Dental coverage
- ◇ I do NOT wish to enroll in the Dental coverage
- ◇ I am covered by another dental plan and I elect to postpone enrollment in the Welfare Fund's Dental coverage until coverage under the other plan ends.

Part E *Choose One*
- △ I elect to enroll in the Vision coverage
- △ I do NOT wish to enroll in the Vision coverage
- △ I am covered by another vision plan and I elect to postpone enrollment in the Welfare Fund's Vision coverage until coverage under the other plan ends.

(TURN PAGE OVER)

Receipt of this form does not guaranty eligibility.

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND RETIREE PLAN OF BENEFITS

12 East Erie Street, Chicago, IL 60611
(312) 787-9455 – Option 4

Enrollment Form for Retiree Health Care Benefits

Spouse Coverage Election - Your Spouse can only be enrolled in the type of coverage in which you are enrolled. You must submit an original county certified birth certificate for your spouse and an original county certified marriage document.

Part A *Choose One*
- △ My spouse is NOT currently Medicare Eligible
- △ My spouse is currently Medicare Eligible (You must submit a copy of your spouse's Medicare card)

Part B *Choose One*
- O My spouse elects to enroll in the Comprehensive Medical Benefits coverage
- O My spouse does NOT wish to enroll in the Comprehensive Medical Benefits coverage
- O My spouse is covered by another comprehensive medical benefit plan and elects to postpone enrollment in the Welfare Fund's Comprehensive Medical Benefits coverage until coverage under the other plan ends.

Part C *Choose One*
- ☐ My spouse elects to enroll in the Prescription Drug coverage
- ☐ My spouse does NOT wish to enroll in the Prescription Drug coverage
- ☐ My spouse is covered by another prescription drug plan and elects to postpone enrollment in the Welfare Fund's Prescription Drug Coverage until coverage under the other plan ends.

Part D *Choose One*
- ◇ My spouse elects to enroll in the Dental coverage
- ◇ My spouse does NOT wish to enroll in the Dental coverage
- ◇ My spouse is covered by another dental plan and elects to postpone enrollment in the Welfare Fund's Dental coverage until coverage under the other plan ends.

Part E *Choose One*
- △ My spouse elects to enroll in the Vision coverage
- △ My spouse does NOT wish to enroll in the Vision coverage
- △ My spouse is covered by another vison plan and elects to postpone enrollment in the Welfare Fund's Vision coverage until coverage under the other plan ends.

Dependent Children Coverage Election

You must complete a separate Dependent Enrollment Form if you wish to enroll dependent children in the Plan. You may download a form from our website at www.crccbenefits.org or you may contact the Retirement Benefits Department to request a form. **Please answer the question below so that we know whether or not we should be expecting a Dependent Enrollment Form from you.**

- △ I do NOT have any dependent children that I wish to enroll in the Plan at this time.
- △ I do have dependent children that I wish to enroll in the Plan and I will be submitting the Dependent Enrollment Form and required supporting documents

I hereby authorize **either** the Chicago Regional Council of Carpenters Pension Fund **or** the Chicago Regional Council of Carpenters Millmen Pension Fund **or** the Carpenters Pension Fund of Illinois **or** the Carpenters Local #496 Pension Fund (hereafter referred to as "Pension Fund") to deduct the appropriate premium(s) from my monthly pension benefit for the coverage under the Chicago Regional Council of Carpenters Welfare Fund Retiree Plan of Benefits ("Welfare Fund") that I have elected. I understand that premium rates may increase at any time. If premiums increase under the Welfare Fund, the Pension Fund is authorized to withhold the increased premium amount from my pension payment.

I understand that, if I am covered by the Chicago Regional Council of Carpenters Welfare Fund Active Plan of Benefits at the time of my retirement, and I elect coverage under the Retiree Plan of Benefits (or defer coverage under the Retiree Plan of Benefits until a later date due to other insurance coverage), then I am waiving my right to continuation coverage under COBRA from the Active Plan of Benefits.

It is fraudulent to fill out this form with information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act.

If any of the information that I have furnished on this form is untrue or incomplete, I agree to reimburse the Chicago Regional Council of Carpenters Welfare Fund for any money it was induced to pay as a result of the information I provided.

Signature of Participant: _____ **Date**: _____

Receipt of this form does not guaranty eligibility.

THIS FORM IS NOT VALID WITHOUT A SIGNATURE AND DATE

CHICAGO REGIONAL COUNCIL OF CARPENTERS
WELFARE FUND
12 EAST ERIE STREET • CHICAGO, IL 60611
(312) 787-9455, OPTION 4 FAX: 312-951-3986

187PIFRETIREE

Retiree Participant Information Form

Instructions: **Print Clearly in Ink**. You must fully complete the form in full, sign and return it along with your Retiree Insurance Enrollment Form.

Part 1 – Participant Information

1. Participant's Last Name First Middle Initial	2. Soc. Sec. Number or Individual Tax ID Number (ITIN):	3. BCBS I.D. Number
4. Participant's Home Address	5. City	6. State / 7. Zip Code
8. Date of Birth: / /	9. Gender: □ Male □ Female	10. Martial Status: (Please check one) □ Single □ Married □ Separated □ Divorced □ Widowed
11. Telephone Number: ( )	12. Cell Phone Number: ( )	
13. Email Address:	14. Are you on Medicare or Tricare? □ Yes □ No If yes, provide Medicare Claim/Tricare Card Number (HIC):	

Part 2 – Spouse Information

1. Spouse's Last Name First Middle Initial	2. Soc. Sec. Number or Individual Tax ID Number (ITIN) (Mandatory):	
3. Date of Birth / /	4. Telephone Number: ( )	5. Are you on Medicare or Tricare? □ Yes □ No If yes, provide Medicare/Tricare Card Number (HIC):
Is Spouse Employed?: □ Yes □ No If Yes, Name of Employer:	6. Employers Telephone Number ( )	
7. Employer's Address	8. City	9. State / 10. Zip Code

Part 3 – Dependent Children Information. Complete all information or the form will be returned to you as incomplete.

1a. Child's Last Name First Middle Initial	1b. Child's Date of Birth / /	1c. Child's Gender: □ Male □ Female	1d. Relationship to Participant: □ Son □ Daughter □ Other Explain Other:
1e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State:		1f. Is Child on Medicare or Tricare? □ Yes □ No If yes, provide Medicare/Tricare Card Number (HIC):	
2a. Child's Last Name First Middle Initial	2b. Child's Date of Birth / /	2c. Child's Gender: □ Male □ Female	2d. Relationship to Participant: □ Son □ Daughter □ Other Explain Other:
2e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State:		2f. Is Child on Medicare or Tricare? □ Yes □ No If yes, provide Medicare/Tricare Card Number (HIC):	
3a. Child's Last Name First Middle Initial	1b. Child's Date of Birth / /	3c. Child's Gender: □ Male □ Female	3d. Relationship to Participant: □ Son □ Daughter □ Other Explain Other:
3e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State:		3f. Is Child on Medicare or Tricare? □ Yes □ No If yes, provide Medicare/Tricare Card Number (HIC):	
4a. Child's Last Name First Middle Initial	4b. Child's Date of Birth / /	4c. Child's Gender: □ Male □ Female	4d. Relationship to Participant: □ Son □ Daughter □ Other Explain Other:
4e. Does the above named child live at same address as Participant: □ Yes □ No If no, list address: City: State:		4f. Is Child on Medicare or Tricare? □ Yes □ No If yes, provide Medicare/Tricare Card Number (HIC):	

5. Do you need to list more dependents? □ Yes □ No If yes, please list them on a separate piece of paper and return with this form.

Part 4 – Other Insurance Information

1. Are you, your Spouse or Dependent Children insured under any other Group Hospital, Medical, Dental or Visions Plan?: □ Yes □ No	2. If yes, Name of Insurance Carrier:	
3. Policy Number:	4. Insurance Carrier's Phone Number: ( )	5. Family members insured under the Group Insurance Policy (check all that apply): □ Self □ Spouse □ All Children □ Child List name(s):

*****PLEASE SEND A COPY OF THE FRONT & BACK OF OTHER INSURANCE AND/OR MEDICARE CARD WHEN YOU RETURN THIS FORM*****

Statement: It is fraudulent to fill out this form with information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse the Chicago Regional Council of Carpenters Welfare Fund for any money it was induced to pay as a result of the information I provided. Receipt of this form is not a guarantee of eligibility.

X _____ Participants Signature Date

X _____ Spouse's Signature Date

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
RETIREE PLAN OF BENEFITS
12 East Erie Street, Chicago, IL 60611
Telephone: (312) 787-9455 – Option 4
Facsimile: (312) 951-3986
Email: pension@crccbenefits.org

PAGE 1 of 2 -- Continuous Coverage Verification Form for Enrollment in the Retiree Health Care Benefits

Retired Carpenter's Name:	Retired Carpenter's SSN# or UID#:

The Chicago Regional Council of Carpenters Welfare Fund Retiree Plan of Benefits ("Retiree Plan") permits retirees and their dependents to postpone enrollment in the Retiree Plan when they have other health plan coverage. They can later enroll in coverage under Retiree Plan if they can provide evidence that they maintained continuous coverage under another health plan during the postponement period. Enrollment in the Retiree Plan is now being requested. In order to process the enrollment, this form must be completed by either the Health Plan or the Employer as evidence of continuous healthcare coverage during the postponement period.

Authorization for Release of Information
The Covered Individual Must Sign and Date This Section Before Sending to the Health Plan or Employer for Completion

I recognize that my health plan eligibility information may be protected under the HIPAA privacy rules. This authorization should be considered a HIPAA authorization for release of health information. I hereby authorize the disclosure of information relating to my coverage under the Plan to the extent necessary for the completion of this form. I understand that after this information is disclosed, federal law might not protect the information. Further, I understand that I have the right to revoke this authorization at any time in writing and that the revocation is only effective after it is received and the revocation will have no effect if it is received after the requested information is released. This authorization will expire on the date the completed form is forwarded to the Chicago Regional Council of Carpenters Welfare Fund. I acknowledge that I am voluntarily signing this form to release my health information directly to the Chicago Regional Council of Carpenters Welfare Fund.

Covered Individual Signature: _____ Date Signed: _____

Covered Individual ID# (from your current health plan ID card): _____

(TURN OVER)

INS CONT COVER

Receipt of this form does not guaranty eligibility.

CHICAGO REGIONAL COUNCIL OF CARPENTERS WELFARE FUND
RETIREE PLAN OF BENEFITS
12 East Erie Street, Chicago, IL 60611
Telephone: (312) 787-9455 – Option 4
Facsimile: (312) 951-3986
Email: pension@crccbenefits.org

PAGE 2 of 2 -- Continuous Coverage Verification Form for Enrollment in the Retiree Health Care Benefits

Retired Carpenter's Name:	Retired Carpenter's SSN# or UID#:

This page of the form must be completed by the other Health Plan or the Employer and returned directly to the Retiree Plan by either mail, facsimile or email. The Plan's contact information appears above.
Please print clearly.

Name of Health Plan (ex: BCBS, Aetna, etc.):				Health Plan ID & Covered Individual ID Number:				
Name of Employer (If Employer Sponsored Plan):								
Health Plan Address and Telephone Number:								
Name of Covered Individual and Each Dependent **(Please List Each Individual Separately)**:	Date Hospital/ Medical Coverage Began:	Date Hospital/ Medical Coverage Ended or Will End:	Date Prescription Drug Coverage Began:	Date Prescription Drug Coverage Ended or Will End:	Date Dental Coverage Began:	Date Dental Coverage Ended or Will End:	Date Vision Coverage Began:	Date Vision Coverage Ended or Will End:
Printed Name of Individual Completing This Form:			Title:		Telephone Number:			
Signature of Individual Completing this Form:					Date Form Completed/Signed:			

Receipt of this form does not guaranty eligibility.