Indiana/Kentucky/Ohio Regional Council of Carpenters' Fringe Benefit Funds

P.O. Box 969, Troy, MI 48099-0969
(800) 700-6756

VITAL INFORMATION FORM

Last: _____ First: _____ Middle: _____

Address/City/State/Zip: _____

Social Security Number: ____-____-____ Date of Birth: ____/____/____ Gender :(*circle one*) Male Female

Marital Status: *(circle one)* Single Married Divorced Separated Widowed

Date of Marriage/Divorce/Separation: _____

Current Status: *(circle one)* Active Retired Disabled COBRA

Telephone Number: (____) _____ Alternate Phone Number: (____) _____

Email Address: _____

Employer_____ Initiation Date: _____

Home Local: _____ Home Fund: _____ UBC#_____

Medicare Claim Number: (including the letter(s) that follows the number)
(This only applies when a member, a spouse, or a covered dependent is age 65 or older or on Medicare disability)

Member # _____ **Spouse #** _____ **Dependent # and Name** _____

DEPENDENTS: - Include Spouse (*Marriage/Birth Certificates are needed to add any new dependents to the plan)*

FULL NAME	RELATIONSHIP	SOCIAL SECURITY NUMBER	DATE OF BIRTH

BENEFICIARY INFORMATION:

NAME	RELATION	SS #	BIRTHDAY	ADDRESS/CITY/STATE/ZIP	%
(Primary)		___-___-___	___/___/____		
		___-___-___	___/___/____		
(Secondary)		___-___-___	___/___/____		
		___-___-___	___/___/____		

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

MEMBER SIGNATURE **Date**

(OVER)

OTHER INSURANCE INQUIRY

Please complete this portion of the form if you, your spouse, or any of your dependents have other insurance coverage that you participate in, or if there has been any change in other insurance coverage.

General Information:

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____) _____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active? _____

Termination date if applicable: _____

Coverage is: (*circle one*) Single Family

Children are covered until age: _____

Type of coverage: (*circle all that apply*) Medical Dental Vision Prescription

List covered dependents: _____

_____

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contain a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

I Have No Other Insurance: _____
Initial Here/Sign Below

Member Signature:_____ **Date:** _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

MEMBER / RETIREE SECTION

I, (print name and social security number) _____ **SSN#**___ ___ ___/___ ___/___ ___ ___ __ authorize the Health Fund (the "Fund"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Fund, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

HIPAA Contact Person
Indiana/Kentucky/Ohio Regional Council of Carpenters' Welfare Fund
P.O. Box 969
Troy, MI 48099-0969
Phone: (800)700-6756
(317) 851-4168
www.in-kycarpentersbenefits.org

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Fund cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member_____**Date Signed:** _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Member_____**Date Signed**: _____

SPOUSE SECTION

I, the **Spouse** (**Name, Please Print**) _____, (**Spouse's Social Security #**) _____of the above named member, have also read, understand, and authorize the Fund to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse_____**Date Signed**: _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Spouse _____ **Date Signed**: _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the **Dependent Child(ren)** over the age of 18 (**Name, Please Print)**_____,**(Social Security #)** _____have also read, understand, and authorize the Fund to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, except at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent_____**Date Signed**: _____

OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Dependent _____**Date Signed**: _____

NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Fund Office.