Central Laborers' Welfare Fund
Other Medical Insurance Coverage Questionnaire

This form is essential in providing the Fund with the necessary information needed to provide affordable coverage to our members. Please complete and return this form in the envelope provided. If you need assistance, please contact our office at 1-217-479-3600 or toll free 1-800-252-6571, OPTION 5.

Date_____

Central Laborers' Member Name_____

Alt ID or Social Security Number_____Date of Birth_____

Dependents Name_____

Do you or anyone have other coverage on this dependent? Medical_____Yes____No Dental____Yes____No

Vision____Yes _____No. If "Yes" please complete the bottom portion of this form. If "No" please sign, date and return this form.

Other Coverage Information

Policyholder_____Date of Birth_____

Relationship to Dependent _____

Policyholder's ID Number or Social Security Number_____

Group Number_____

Insurance Company Name and Phone_____
**This information can be obtained from the identification card.

Effective Date of Policy_____Termination Date, if applicable_____

Covered Dependents on this policy_____

Does this coverage include:

_____Medical _____Dental _____Vision _____Prescriptions

If this coverage does not include Dental, do you have any dental coverage?____Yes ____No
**If yes, please list dental information below.

Dental Insurance Company Name and Phone Number_____

Covered Dependents on this policy_____

_____ _____
Member Signature Date

Please submit a copy of the front and back of the insurance identification card(s) if applicable.