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.

Date_____

Central Laborers' Member Name_____

Alt ID or Social Security Number_____Date of Birth_____

Dependent's Name_____

Is there a Divorce Decree or Legal Document showing responsibility for coverage on the dependent?_____Yes____No
If "Yes" please provide a filed signed copy.

Do you or anyone have other coverage on this dependent?
Medical_____Yes_____No Dental_____Yes_____No Vision_____Yes_____No
If "Yes" please complete the Other Coverage Information below. 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.