2020 LOCAL 705 I. B. T. HEALTH & WELFARE FUND
PARTICIPANT AND DEPENDENT RECORD

Please complete this form in its entirety for yourself, your spouse and each dependent child.

Participant Name:_____ SSN:_____ Sex___

Address:_____ City/State/Zip:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Email Address:_____

Employer:_____ Hire Date:_____

Current Marital Status: ☐ Single ☐ Divorced ☐ Married ☐ Widowed ☐ Legally Separated

Date of Marriage:_____ Date of Legal Separation/Divorce:_____

If married, please provide your spouse's information below:

Spouse's Name:_____ SSN:_____ Sex___

Date of Birth:_____ Phone:_____

Spouse's Employer:_____ ☐ Not Employed

Address of Spouse's Employer:_____ Phone:_____

Does your spouse carry insurance with his/her employer? ☐ Yes ☐ No (If yes, please provide a copy of both sides of insurance card.)

Name of Insurance Company_____

Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

Please check whether single or family coverage: ☐ Single ☐ Family

I hereby certify that the information given on this participant and dependent record is true, correct and complete. If any of the information provided changes you must notify the Fund Office within 30 days.

Participant's Signature:_____ Date:_____

PLEASE COMPLETE REVERSE SIDE FOR DEPENDENT CHILDREN

PLEASE RETURN COMPLETED FORM TO:
LOCAL 705 I. B. T. HEALTH & WELFARE FUND – ATTN: ELIGIBILITY DEPT.
1645 W. JACKSON BLVD., SUITE 700
CHICAGO, IL 60612

RECORD OF DEPENDENT CHILDREN

Child's Name:______________________________Date of Birth:________________SSN:________________________Sex____
Child's Address (if different from Participant's):____

Does this child have any other insurance coverage (through biological parent, step-parent, etc.)? ☐ Yes ☐ No
(If yes, please provide a copy of both sides of insurance card.)
Name of Insurance Company____
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

If this is an adult dependent child, please provide the following information (if applicable):
Name and Address of Employer:____
Does he/she carry insurance with his/her employer? ☐ Yes ☐ No (If yes, please provide a copy of both sides of insurance card.)
Name of Insurance Company____
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription
If this adult child is married, does his/her spouse carry insurance? ☐ Yes ☐ No (If yes, please provide a copy of both sides of insurance card.)
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

Child's Name:______________________________Date of Birth:________________SSN:________________________Sex____
Child's Address (if different from Participant's):____

Does this child have any other insurance coverage (through biological parent, step-parent, etc.)? ☐ Yes ☐ No
(If yes, please provide a copy of both sides of insurance card.)
Name of Insurance Company____
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

If this is an adult dependent child, please provide the following information (if applicable):
Name and Address of Employer:____
Does he/she carry insurance with his/her employer? ☐ Yes ☐ No (If yes, please provide a copy of both sides of insurance card.)
Name of Insurance Company____
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription
If this adult child is married, does his/her spouse carry insurance? ☐ Yes ☐ No (If yes, please provide a copy of both sides of insurance card.)
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

Child's Name:______________________________Date of Birth:________________SSN:________________________Sex____
Child's Address (if different from Participant's):____

Does this child have any other insurance coverage (through biological parent, step-parent, etc.)? ☐ Yes ☐ No
(If yes, please provide a copy of both sides of insurance card.)
Name of Insurance Company____
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

If this is an adult dependent child, please provide the following information (if applicable):
Name and Address of Employer:____
Does he/she carry insurance with his/her employer? ☐ Yes ☐ No (If yes, please provide a copy of both sides of insurance card.)
Name of Insurance Company____
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription
If this adult child is married, does his/her spouse carry insurance? ☐ Yes ☐ No (If yes, please provide a copy of both sides of insurance card.)
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription