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

Please complete this form in its entirety.

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

HAS YOUR MARITAL STATUS CHANGED WITHIN THE LAST YEAR? ☐ YES ☐ NO

If yes, please provide the details:_____

_____

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

Spouse's Name:_____ SSN:_____ Sex:__

Date of Birth:_____ 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. of T. HEALTH & WELFARE FUND – ATTN: ELIGIBILITY DEPT.
1645 W. JACKSON BLVD., SUITE 700
CHICAGO, IL 60612

RECORD OF DEPENDENT CHILDREN

If any of your dependents have other insurance coverage, please provide a copy of both sides of the insurance card.

1) Child's Name: _____ Date of Birth: _____ Sex: ___
SSN: _____ Phone Number: _____
Child's Address (if different from Participant's): _____
_____

Does this child have any other insurance coverage (through biological parent, step-parent, etc. OR, for adult children, through employer or spouse)? ☐ Yes ☐ No
If yes:
Name of Insurance Company _____
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

2) Child's Name: _____ Date of Birth: _____ Sex: ___
SSN: _____ Phone Number: _____
Child's Address (if different from Participant's): _____
_____

Does this child have any other insurance coverage (through biological parent, step-parent, etc. OR, for adult children, through employer or spouse)? ☐ Yes ☐ No
If yes:
Name of Insurance Company _____
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

3) Child's Name: _____ Date of Birth: _____ Sex: ___
SSN: _____ Phone Number: _____
Child's Address (if different from Participant's): _____
_____

Does this child have any other insurance coverage (through biological parent, step-parent, etc. OR, for adult children, through employer or spouse)? ☐ Yes ☐ No
If yes:
Name of Insurance Company _____
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

4) Child's Name: _____ Date of Birth: _____ Sex: ___
SSN: _____ Phone Number: _____
Child's Address (if different from Participant's): _____
_____

Does this child have any other insurance coverage (through biological parent, step-parent, etc. OR, for adult children, through employer or spouse)? ☐ Yes ☐ No
If yes:
Name of Insurance Company _____
Please check all types of coverage provided: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER IF YOU NEED MORE SPACE.