

# CONSTRUCTION INDUSTRY LABORERS

## FRINGE BENEFIT FUNDS

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Kansas City, MO 64190-9500  
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Managed for the Trustees by  
Wilson-McShane Corporation

# INFORMATION VERIFICATION FORM

Please complete the front and back of this form, sign at the bottom of the last page and return. This form can be emailed or faxed to the contact information listed above.

### Participant Information

Check One:  Male  Female

\_\_\_\_\_  
Last Name First Name Middle Initial

\_\_\_\_\_  
Social Security Number Birth Date (MM/DD/YYYY) (\_\_\_\_\_) Phone Number  
Area Code

\_\_\_\_\_  
Home Address Apartment Number

\_\_\_\_\_  
City County State Zip Code Email Address

Check One:  Single  Married  Widowed  Separated  Divorced: \_\_\_\_\_  
Date of Divorce (MM/DD/YYYY)

Check the following languages in which you are literate:  English  Spanish  Other

Are you a policyholder of any other group medical, vision or dental plan other than Medicare?  Yes  No

Are you entitled to Medicare Part A or B?  Yes  No *If yes, submit a copy of your Medicare Card if it has not been previously submitted.*

Is your spouse offered group health coverage through his/her employer (whether they have accepted the other coverage or not)?  Yes  No

### Dependent Information

List all eligible dependents to be covered.

*If you are adding a spouse, please include a copy of your marriage certificate. County filed copies only. Souvenir copies are not accepted.  
If you are adding a child, please include a copy of their birth certificate. State issued copy only. Souvenir copies are not accepted.  
If either you or your spouse are divorced and you are adding a child or stepchild, submit a copy of the divorce decree and any settlement agreement made part of the decree stating custody and medical responsibility for the children. The decree must be signed and dated by the judge.*

Relationship (Spouse, Son, Stepdaughter)	Social Security Number	Last Name	First Name and Middle Initial	Date of Birth (MM/DD/YYYY)	Does this person have other group medical, vision, prescription, or dental coverage? (Including Medicare)
Spouse: <input type="checkbox"/> M <input type="checkbox"/> F					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No
					<input type="checkbox"/> Yes <input type="checkbox"/> No

Note: This form MUST be signed and dated on page 2 to be valid

If a dependent child or stepchild is listed and the child's parents are divorced, submit a copy of the divorce decree and complete the following for each affected child:

Last Name	First Name and Middle Initial	Who has custody?	Who has Medical Responsibility as stated in the Divorce Decree?	Does the child live in your home? If no, please provide child's home address.
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No
				<input type="checkbox"/> Yes <input type="checkbox"/> No

**Declaration of Other Coverage**

Please complete for the Participant and each dependent that has any other group medical, vision, prescription, or dental coverage (including Medicare). Attach a separate sheet if necessary. Submit a copy of card(s) for each carrier.

<b>Other Policy #1</b>	
Policy Holder: _____	Policy or Group Number: _____
Policy Holder's Social Security Number: _____	Does the plan cover dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Name: _____	Employer's Name: _____
Plan Address: _____	Plan Phone Number: _____
Status for Plan Coverage: <input type="checkbox"/> Active <input type="checkbox"/> Retired Follows Birthday Rule*: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Effective Date of Coverage: _____ Termination Date: _____	
Benefits Provided:	
Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health/Substance Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Prescription: <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Other Policy #2</b>	
Policy Holder: _____	Policy or Group Number: _____
Policy Holder's Social Security Number: _____	Does the plan cover dependents? <input type="checkbox"/> Yes <input type="checkbox"/> No
Plan Name: _____	Employer's Name: _____
Plan Address: _____	Plan Phone Number: _____
Status for Plan Coverage: <input type="checkbox"/> Active <input type="checkbox"/> Retired Follows Birthday Rule*: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Effective Date of Coverage: _____ Termination Date: _____	
Benefits Provided:	
Medical: <input type="checkbox"/> Yes <input type="checkbox"/> No Dental: <input type="checkbox"/> Yes <input type="checkbox"/> No Vision: <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Health/Substance Abuse: <input type="checkbox"/> Yes <input type="checkbox"/> No Prescription: <input type="checkbox"/> Yes <input type="checkbox"/> No	

\* The birthday rule is a coordination of benefits rule that some plans use to determine which coverage is primary.

**Acknowledgement**

If married, both the Participant and Spouse must sign below.

I understand that if I or my dependents provide false information to the Construction Industry Laborers Welfare Fund or conceal information, we could be subject to severe penalties under state and federal law and the Fund may seek to recover benefits wrongfully paid or pursue legal remedies against us. I declare under penalty of perjury that the foregoing is true and correct.

**AUTHORIZATION**

I agree, for myself and my dependents, that in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act of omission of another person to fully inform Construction Industry Laborers Welfare Fund and that I will execute such assignments, liens or other documents which may be necessary to enable Construction Industry Laborers Welfare Fund to recover the value of benefits provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided, I will immediately reimburse Construction Industry Laborers Welfare Fund to the extent of services provided and to the extent as specified by the plan. **FRAUD WARNING** Any person who, knowingly and with intent to defraud the Fund or other person: (1) files an application for benefits or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits, a fraudulent act and may be subject legal action

Participant's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_

FOR INTERNAL USE ONLY  
 MC REC: \_\_\_\_\_ BC REC: \_\_\_\_\_ DD REC: \_\_\_\_\_ REQ ON: \_\_\_\_\_ BY: \_\_\_\_\_