BEER INDUSTRY LOCAL UNION NO.703 HEALTH AND WELFARE FUND
18660 GRAPHIC DRIVE, SUITE 202, TINLEY PARK ILLINOIS 60477
TELEPHONE: (708) 429-0046 FAX: (708) 429-0047
WEBSITE: WWW.CBIBF.ORG

# STEPCHILD INSURANCE VERIFICATION

**STEPCHILD INSURANCE VERIFICATION FORM MUST BE FILED WITH THE FUND OFFICE EACH YEAR. THIS FORM EXPIRES 12-31-24.**

Participant Name: _____Date: _____

The child(ren) named below, is/are my stepchild(ren)

| | |
|---|---|
| _____ | _____ |
| (name of stepchild) | (date of birth) |
| _____ | _____ |
| (name of stepchild) | (date of birth) |
| _____ | _____ |
| (name of stepchild) | (date of birth) |

## Please indicate one of the following below:

**_____The above stated child(ren) have health insurance through a different insurance plan. If you checked this area, please complete the following:**

**Name of Subscriber**:_____**Date of Birth: _____**

| ***MEDICAL*** | ***RX*** | ***DENTAL*** |
|---|---|---|
| Yes_____ No_____ | Yes_____ No_____ | Yes_____ No_____ |
| Single_____ Family_____ | Single_____ Family_____ | Single_____ Family_____ |
| Effective date _____ | Effective date _____ | Effective date _____ |

Name of Insurance Company:

_____

Insurance Company Telephone Number

( _____ ) _____

Type of Plan: HMO_____ PPO _____ OTHER_____

**_____ The above stated child(ren) are not currently covered under any other health insurance plan. I will notify the Fund Office if they become covered under any other insurance plan.**

| | |
|---|---|
| _____ | _____ |
| **Participant Signature** | **Participant Social Security No.** |