BEER INDUSTRY-
LOCAL UNION NO. 703 HEALTH AND WELFARE FUND

18660 Graphic Drive, Suite 202 · Tinley Park, Illinois 60477
Telephone: (708) 429-0046 * www.cbibf.org * Fax: (708) 429-0047

OTHER INSURANCE VERIFICATION – ADULT CHILD

(MUST BE FILLED OUT BY ADULT CHILD)

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

Participant's Name: _____ ID _____

Dependent's Name: _____

DEPENDENTS STATUS:

Employed ____Unemployed ____Student____ Disabled____ Married _____ if yes, Date of Marriage _____

Adult Dependent's Address **City** **State** **Phone Number**

Adult Dependent's Signature **Date**

IF YOUR DEPENDENT IS EMPLOYED, THE EMPLOYER MUST FILL OUT THE BOTTOM PART OF THIS FORM. IF NOT EMPLOYED, PLEASE RETURN FORM TO THE FUND OFFICE.

DEPENDENT'S EMPLOYEE AUTHORIZATION TO RELEASE DATA:

AUTHORIZATION: I authorize my employer, _____, to disclose protected health information regarding my insured status and eligibility for insurance to Beer Industry – Local Union No. 703 Health and Welfare Fund. Further, I authorize my employer to complete this form and return it to Beer Industry Local 703.

Signature of adult child or adult child's spouse: _____

ALL INFORMATION BELOW IS TO BE COMPLETED BY THE EMPLOYER ONLY

DEAR EMPLOYER:
Our participant requests the Health & Welfare Fund provide insurance coverage for his/her **ADULT DEPENDENT CHILD**, who is your employee. To process this request, it is important that the employer answers the following questions. Please answer all applicable questions and return this form to the Fund Office

Do you offer a health plan for this employee? Yes _____ No _____

If No, please sign and return the form to the Fund Office.

If Yes,

1. What date **will/did** this employee become eligible for coverage? _____
2. Has this employee waived their insurance option? Yes _____No_____
3. If this employee is currently enrolled in your health plan, please verify the type of coverage below.

Name of Insurance Company: _____

Insurance Company Telephone Number (_____) _____

Type of Plan: HMO_____ PPO _____ OTHER_____

MEDICAL
Yes_____ No_____
Single_____ Family_____
Effective date _____

RX
Yes_____ No_____
Single_____ Family_____
Effective date _____

_____ **(Printed name of person completing this form)**

_____ **(Signature of person completing this form)**

Title/Position: _____ Date: _____ Telephone: _____

Adult Child (Dependent) needs to complete the top portion of form.

If your Adult Child (Dependent) is working in any capacity (full-time, part-time, casual, etc.) this form must be signed and dated by him/her in the Employee Authorization to Release Information section and then GIVEN TO THEIR EMPLOYER for completion with the enclosed envelope and returned.

If your Adult Child (Dependent) is not working in any capacity, Adult Child (Dependent) must complete the top of this form and simply draw an "X" on the section for Employer to complete. The form must then be returned to the Fund Office with the Claim Form or in the enclosed envelope.

A new form is also required to be completed and returned to the Beer Industry – Local Union No. 703 Health and Welfare Fund anytime there is a change in the working status of your Adult Child (Dependent).

The Fund Office will mail this form **annually** and must be completed and returned to receive coverage. A new form can be mailed upon request.

This form can be scanned and uploaded to our website: www.cbibf.org in the "Contact Us" section.