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

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

OTHER INSURANCE VERIFICATION – OTHER PARENT

(MUST BE FILLED OUT BY OTHER PARENT'S EMPLOYER)

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

EMPLOYEE AUTHORIZATION TO RELEASE DATA:

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.

Employee (Other Parent) name: _____
Please print

Employee (Other Parent) Signature: _____

DEAR EMPLOYER:

Our participant requests the Health & Welfare Fund provide insurance coverage for his dependent child(ren),

_____, under his Plan. To process this request, it is important that you,
Childrens Name(s)

the employer, answer the following questions. Please answer all applicable questions and return this form to the Fund Office. Insurance coverage, if eligible, will **NOT** be provided if this form is incomplete or not returned.

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: _____

TO BE COMPLETED BY PARTICIPANT:	
Participant Name:	SSN: XXX – XX -

Participants need to fill out the bottom section of form “TO BE COMPLETED BY PARTICIPANT”.

Other Parent needs to complete top portion of form. Please note this form is used to determine whether your dependent has other insurance coverage.

If Other Parent 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 Other Parent is not working in any capacity, Other Parent must sign 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 the Other Parent.

The Fund Office will mail this form **annually** and must be completed and returned to receive coverage for dependents. 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.