BEER INDUSTRY-
LOCAL UNION NO. 703 HEALTH AND WELFARE FUND
18660 Graphic Drive, Suite 202 · Tinley Park, Illinois 60477
Telephone: (708) 429-0046 · Website: cbibf.org - Fax: (708) 429-0047

OTHER INSURANCE VERIFICATION - SPOUSE

(***MUST BE FILLED OUT BY SPOUSE AND SPOUSE'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, _____, to disclose protected health information regarding
Spouse's Employer Name
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.

Spouse's name: _____
Please print

Spouse's Signature: _____*Date*: _____

DEAR EMPLOYER:

Our participant requests the Health & Welfare Fund provide insurance coverage for your employee, named above, under our Plan. To process this request, it is important that you, 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.

Employment Status: The above-named individual works _____ hours per week and is a full-time or part-time employee. Part-time effective date: _____ or Full-time effective date: _____.

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	***RX***
Yes_____ No_____	Yes_____ No_____
Single_____ Family_____	Single_____ Family_____
Effective date _____	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 this form.
"TO BE COMPLETED BY PARTICIPANT".

If your spouse is working in any capacity (full-time, part-time, casual, etc.) this form must be signed and dated at the top by your spouse and then GIVEN TO YOUR SPOUSES' EMPLOYER for completion with the enclosed envelope and returned.

If your spouse is not working in any capacity, your spouse must sign and date 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.

Please be advised it is your responsibility to notify the Beer Industry – Local No. 703 Health and Welfare Fund if your spouse's working status changes anytime during the covered period. You are required to remit the correct cost based on the spouse's working or non-working status during the entire coverage period.

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.