## **BEER INDUSTRY - LOCAL UNION NO. 703 HEALTH & WELFARE FUND**

**18660 Graphic Drive Suite 202** Tinley Park, IL 60477

Telephone (708) 429-0046 \*\* Website: www.cbibf.org \*\*Fax: (708) 429-0047

## **CLAIM FORM**

A CLAIM FORM MUST BE FILED WITH THE FUND OFFICE EACH YEAR. THIS FORM EXPIRES 12-31-24.				
Participant's Name		Social Security Nur	mber	Date of Birth
		XXX-XX-		
Home Address		Marital Status		Medicare Coverage
		Single		(SelfSpouse)
		Divorced		Hospital (Part A)
		Married		Medicare (Part B)
City State	Zip	Widowed		Both (Part A & B)
Telephone Number		Date of Marriage:		Effective Date:
Spouse's Name				
Spouse's Telephone Number	Social Security Number	Date of Birth	Snouse's Emi	ployment Status
Spouse & receptione runiber	Social Security Number			RetiredUnemployed
If Spouse, is Employed, Give Full Name & Address of Spouse's Employer:				
City State	Zip Telephone 1	Number		
PLEASE LIST SPOUSE / DEPENDENT'S COVERED UNDER YOUR INSURANCE:				
Spouse / Dependent's Names Social Secu		ity Number Birthdates Is This Dependent Covered Under Any Other Insurance (Y/N)		
1.				
				<del></del>
2.				
3.				
4.	<del></del>			
<u>5.</u>	_			<del></del>
<u>6.</u>	_			
7	_			
IF YOU OR ANY MEMBER OF YOUR FAMILY IS COVERED UNDER ANOTHER MEDICAL HEALTH PLAN, COMPLETE THE FOLLOWING				
Covered Family Member	COMILETE	Type of Plan	G	Type of Coverage
SelfSpouseDepen	dent	Individual		SingleFamily
				<i>y v</i>
		Group		
Name and Address of Insurance Company				Policy or Plan No.
	-			Ins. ID Number
City	State Zip			
Telephone Number				

**Participant's Signature** 

This form must be completed by you, the participant, so the Fund Office can update your personal data. This information is valuable to you because it assists the Fund Office in processing any claims submitted on your behalf or that of your dependents, if applicable.

## Please answer every question on this form.

If a section does not apply, please write N/A in that box. By doing this we will know that you did not overlook the question in error.

<u>Important</u>: If you check **ACTIVE** in the Spouse's Employment Status box, you **MUST** have the OTHER INSURANCE VERIFICATION - SPOUSE, form completed by your spouse and spouse's employer.

Please be sure to sign and date the bottom of this form.

Failure to complete and return this form will cause the Fund Office to deny claims received on behalf of your dependents, if applicable.

This form can be scanned and uploaded to our website: <a href="www.cbibf.org">www.cbibf.org</a> in the "Contact Us" section.