Central Laborers' Welfare Fund

P.O. Box 1267 • Jacksonville, Illinois 62651 • Phone 217/243-8521 • Fax 217/243-8619

http://www.central-laborers.com

CENTRAL LABORERS' WELFARE FUND
DEPENDENT INSURANCE COVERAGE INFORMATION

(To be completed by dependent's employer)

Your Employee's Name: ____________________

On what date was your employee hired? ____________________

Is employee eligible for your employer-sponsored group health insurance plan? ☐ Yes ☐ No

If yes, when was the employee first eligible for your employer-sponsored plan? ____________ Month/Day/Year

Is the employee currently enrolled in your insurance plan(s)? ☐ Yes ☐ No
If yes, please note the coverage: ☐ Health ☐ Prescription ☐ Dental ☐ Vision

If employee is NOT currently enrolled in your health plan, when will the employee be eligible to enroll in the plan? Effective Date: ____________ Month/Day/Year

Employer Name: ____________________ **Employer Address:** ____________________
Employer Telephone: ____________________

Health Insurance Carrier Name: ____________________ **Phone Number:** ____________
Group and Policy Number: ____________________

Prescription Drug Carrier Name: ____________________ **Phone Number:** ____________
Group and Policy Number: ____________________

Dental Insurance Carrier Name: ____________________ **Phone Number:** ____________
Group and Policy Number: ____________________

Vision Insurance Carrier Name: ____________________ **Phone Number:** ____________
Group and Policy Number: ____________________

Completed By: ____
Signature Date

____
Please print Name and Title

Dependent's Authorization to Release Information: I hereby authorize my employer to release the information requested above to Central Laborers' Welfare Fund for the sole purpose of ascertaining eligibility for enrollment in my employer-sponsored plan.

____
Dependent's Signature Date

Member's Certification: I certify that the above information is correct and that I understand my responsibility to notify you of any changes. I understand that if my dependent was eligible to participate in his or her employment-based health coverage prior to January 1, 2022 and declined such coverage, then this plan will only pay 20% of any otherwise allowable charges.

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Member Signature ID# Date