Central Laborers' Welfare Fund
Other Medical Insurance Coverage Questionnaire

This form is essential in providing the Fund with the necessary information needed to provide affordable coverage to our members. Please complete and return this form in the envelope provided. If you need assistance, please contact our office at 1-217-243-8521 or toll free 1-800-252-6571 ext. 120 or 133.

Date______________________

Central Laborers' Member Name____

Alt ID or Social Security Number_________________________________Date of Birth_______________________

Dependents Name____

Do you or anyone have other coverage on this dependent? Medical_____Yes____No Dental____Yes____No

Vision____Yes _____No. If "Yes" please complete the bottom portion of this form. If "No" please sign, date and return this form.

Other Coverage Information

Policyholder____Date of Birth_______________________________

Relationship to Dependent ____

Policyholder's ID Number or Social Security Number___________________________________

Group Number__________________________

Insurance Company Name and Phone____
**This information can be obtained from the identification card.

Effective Date of Policy__________________________Termination Date, if applicable_______________________

Covered Dependents on this policy____

Does this coverage include:

_____________Medical _____________Dental _____________Vision _____________Prescriptions

If this coverage does not include Dental, do you have any dental coverage?____Yes ____No
**If yes, please list dental information below.

Dental Insurance Company Name and Phone Number____

Covered Dependents on this policy____

____ ______________________________
Member Signature Date

Please submit a copy of the front and back of the insurance identification card(s) if applicable.