

Carpenter's District Council of Kansas City & Vicinity Welfare Fund

3100 Broadway, Suite 805
Kansas City \, Missouri 64111-2413
(816) 756-3313 or toll free (866) 756-3313
email fringebens@goldengate.net
www.kccarpsbenefits.com

Each calendar year it is necessary to update our records for the Fund Office. Please provide the following information, in lieu of a claim form, for each member. During the year, you may also be required to complete a claim form or forms if a bill is received that appears to be accident related.

Insured's Data

Name _____

Address _____

Social Security # _____ Date of Birth _____

Spouse's Data

Name _____

Social Security # _____ Date of Birth _____

Spouse's Employer's Name _____

Employer's Address _____ Phone # _____

City _____ State _____ Zip Code _____

Does your spouse have other Group Medical Coverage? Yes No

If yes, is the coverage type: Single? Family?

Medical Insurance Carrier Name _____ Phone # _____

Insurance Address _____

Group Contract # _____ Effective Date _____ Term Date _____

Does coverage include Dental? Vision?

Please provide the complete names & birth dates, etc, for all covered dependents. If a dependent child is employed and/or has other insurance, please include that information. In addition, if you are married, please attach a copy of your marriage certificate. If there is a divorce decree that addresses medical coverage for any dependent children, please supply a copy of that decree.

Dependent's Name	Relationship	DOB	Social Security #	Employer/Other Insurance

If any of the above information changes during the calendar year, you must advise us immediately. See page 2 of this form for further guidelines.

We are pleased to be of service to you. Please contact this office if you have any questions.

Please sign below, verifying that the above statements are true to the best of your knowledge and belief. Your signature will also authorize an institution or physician to release information concerning your enrollment, related records and medical records to the Fund Office, if needed.

Participant's Signature

Date of Signature

