Health Insurance Verification Form

Return before August 31, 2015

NOTE: If you do not return this form, your spouse's Culinary coverage will end and their claims will be denied.

PART A: YOUR INFORMATION

LAST NAME	FIRST NAME	M.I.	SOCIAL SECURITY NO.	BIRTHDATE	SEX (M/F)

HOME ADDRESS	CITY	STATE	ZIP CODE

TELEPHONE	MARITAL STATUS	LANGUAGE PREFERENCE	E-MAIL ADDRESS
	☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ WIDOW	☐ English ☐ Spanish ☐ Other _____	

PART B: YOUR DEPENDENT SPOUSE INFORMATION. COMPLETE THIS SECTION TO CONTINUE TO COVER YOUR ELIGIBLE SPOUSE.

LAST NAME OF SPOUSE	FIRST NAME OF SPOUSE	M.I.	SOCIAL SECURITY NO.	BIRTHDATE	SEX (M/F)

Is your spouse employed? ☐ **NO** ☐ **YES** – Please complete Section 1 below.

Is your spouse a retiree? ☐ **NO** ☐ **YES** – If YES, is insurance offered through retirement? ☐ **NO** ☐ **YES** complete Section 2a below.

Is your spouse covered by Medicare or Medicaid? ☐ **NO** ☐ **YES** – by ☐ Medicare ☐ Medicaid, complete Section 2a below.

Section 1. IF YES, please indicate:

1. Employer's Name: _____

2. Is your spouse covered by his/her employer's Health Plan? ☐ **YES** - Please complete Section 2a. ☐ **NO** - Please complete Section 2b.

Section 2. Spouse other insurance information:

2a. If YES, please indicate:

Insurance Name: _____

Address: _____

Phone No: _____

Policy Number: _____ Effective Date: _____

Insurance type: ☐ Single ☐ Family **Coverage Type:** ☐ Medical ☐ Dental

(Check all that apply)

2b. If NO, please provide reason:

☐ Insurance is not offered

☐ Part Time Employee – not eligible for health benefits

☐ Spouse is eligible but not signed up

☐ New employee, will be eligible in _____ (month/year)

PART C: YOUR DEPENDENT CHILDREN INFORMATION. ARE ANY OF YOUR DEPENDENT CHILDREN INSURED UNDER ANY OTHER GROUP MEDICAL OR DENTAL INSURANCE – (INCLUDING STUDENT, ACCIDENT, OR GOVERNMENT PLAN)? IF YES, COMPLETE THE NEXT LINES

Dependent Children (for more children use back of form)	**Coverage offered by** (Name of Non-Culinary Parent)	**Insurance Name and Address**	**Policy Number and Effective Date**	**Type of Coverage (Check all that apply)**
				☐ **Medical** ☐ **Dental**
				☐ **Medical** ☐ **Dental**
				☐ **Medical** ☐ **Dental**
				☐ **Medical** ☐ **Dental**
				☐ **Medical** ☐ **Dental**
				☐ **Medical** ☐ **Dental**
				☐ **Medical** ☐ **Dental**
				☐ **Medical** ☐ **Dental**
				☐ **Medical** ☐ **Dental**

CONSENT INFORMATION

By my signature below, I acknowledge that the Culinary Health Fund and its authorized agents may use and disclose health information for purposes related to evaluating, processing, and reviewing my claims or my dependent's claims, and I consent to the disclosure of information requested by the Culinary Health Fund by any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policy holder, employer or benefit plan administrator.

This consent will be valid for the entire period of my eligibility and my dependent's eligibility under the Fund's plan of benefits.

I hereby certify that all information provided on this form is accurate and complete to the best of my knowledge.

_____ _____

Culinary Covered Employee Signature **Date**

RETURN FORM TO: CULINARY HEALTH FUND 1901 Las Vegas Blvd., South Suite 107 Las Vegas, NV 89104 – 1309

(702) 733-9938 www.culinaryhealthfund.org

July 2015