CONNECTICUT LABORERS' HEALTH FUND
CENSUS INFORMATION

INSTRUCTIONS: Please complete the form for yourself and any eligible dependents and please be sure to submit the required documents. Once complete, please sign and date the bottom of the form.

MEMBER INFORMATION:

Name: _____ SS#:_____ Date of Birth: _____
Street Address:_____ City: _____ State:_____
Zip Code:_____ Phone:( )_____ Cell:( )_____ Email:_____Local Union:_____
Marital Status: ❒ Married ❒ Divorced ❒ Widowed ❒ Single (Never Married) ❒ Legally Separated

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SPOUSE INFORMATION
IMPORTANT: Please provide Spouse's Birth Certificate (Long Form) & Marriage Certificate
Spouse's Name: _____ SS#:_____ Date of Birth: _____
Date of Marriage: _____ Name of Spouse's Employer:_____
Address of Spouse's Employer:_____
Does your spouse have coverage through employment? ❒ Yes ❒ No
If you answered "YES" please provide the name of your spouse's health coverage:_____
Please check all that apply: ❒ Medical ❒ Dental ❒ Prescription Drugs ❒ Vision
Name, Address and Telephone Number for your spouse's Plan:_____
_____

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ELIGIBLE DEPENDENT CHILD INFORMATION
IMPORTANT: Please provide your dependent's Birth Certificate (Long Form)
Child's Name: _____ SS#:_____ Date of Birth: _____
Relationship: ❒ Natural Child ❒ Adopted Child ❒ Step Child
Does your child have health insurance through employment or through another individual? ❒ Yes ❒ No
If Yes, Please provide details, i.e., who your child has coverage through, name, address and telephone number of the other Plan, etc._____
_____

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ELIGIBLE DEPENDENT CHILD INFORMATION
IMPORTANT: Please provide your dependent's Birth Certificate (Long Form)
Child's Name: _____ SS#:_____ Date of Birth: _____
Relationship: ❒ Natural Child ❒ Adopted Child ❒ Step Child
Does your child have health insurance through employment or through another individual? ❒ Yes ❒ No
If Yes, Please provide details, i.e., who your child has coverage through, name, address and telephone number of the other Plan, etc._____
_____

I hereby confirm that the information provided is accurate and complete. I Understand that the information provided will be relied upon in determining eligibility for benefits and processing claims for benefits.

_____ _____
Signature Date