

WARNING: NO BENEFITS CAN BE PROVIDED UNLESS A COMPLETED ENROLLMENT FORM IS ON FILE IN THE FUND OFFICE.

# UNITED FURNITURE WORKERS INSURANCE FUND

1910 AIR LANE DRIVE - NASHVILLE, TENNESSEE 37210  
Phone - 615.889.8860 Fax - 615.391.0865

## CLAIM FORM

CLAIM FORM MUST BE COMPLETED BY MEMBER. THIS FORM MUST BE COMPLETED ANNUALLY.

Last Name _____	First Name _____	Mid. Init. _____
Street Address _____	City _____	State _____ Zip _____
Telephone # ( ) _____	Social Security # _____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Date of Birth _____	Employer's Name _____	Local # _____
<b>Marital/Relationship Status:</b>		
<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Domestic Partnership
<input type="checkbox"/> Legally Separated	Date of Legal Separation ____/____/____	
<input type="checkbox"/> Divorced	Date of Divorce ____/____/____	
<input type="checkbox"/> Terminated Domestic Partnership	Date of Termination of Domestic Partnership ____/____/____	

I certify the accuracy of this information and understand that I must inform the Fund of any changes.

_____	_____
Member's Signature	Date

### DEPENDENT AND OTHER INSURANCE INFORMATION (MUST BE COMPLETED IF DEPENDENT COVERAGE IS ELECTED)

#### SPOUSE/DOMESTIC PARTNER

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female

Employed  Yes  No Name of Employer \_\_\_\_\_ Employer Tel. # \_\_\_\_\_

Name of Insurance Carrier \_\_\_\_\_ Telephone # \_\_\_\_\_ Policy No. \_\_\_\_\_

Please check all coverages provided by Insurance Company for Spouse or Domestic Partner

Medical  Prescription Drug  Chiropractic  Dental  Vision

#### DEPENDENT CHILDREN

NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female Full Time Student:  Yes  No

Relationship to You \_\_\_\_\_ Employed  Yes  No Name of Employer \_\_\_\_\_ Employer Tel. # \_\_\_\_\_

Name of Insurance Carrier \_\_\_\_\_ Telephone # \_\_\_\_\_ Policy # \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Policy Holder's Relationship to Dependent \_\_\_\_\_

Please check all coverages provided by Insurance Company for Dependent

Medical  Prescription Drug  Chiropractic  Dental  Vision

Please use reverse side for additional dependents.

**DEPENDENT CHILDREN**

NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female Full Time Student:  Yes  No  
Relationship to You \_\_\_\_\_ Employed  Yes  No Name of Employer \_\_\_\_\_ Employer Tel. # \_\_\_\_\_  
Name of Insurance Carrier \_\_\_\_\_ Telephone # \_\_\_\_\_ Policy # \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Policy Holder's Relationship to Dependent \_\_\_\_\_  
Please check all coverages provided by Insurance Company for Dependent  
 Medical  Prescription Drug  Chiropractic  Dental  Vision

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NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female Full Time Student:  Yes  No  
Relationship to You \_\_\_\_\_ Employed  Yes  No Name of Employer \_\_\_\_\_ Employer Tel. # \_\_\_\_\_  
Name of Insurance Carrier \_\_\_\_\_ Telephone # \_\_\_\_\_ Policy # \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Policy Holder's Relationship to Dependent \_\_\_\_\_  
Please check all coverages provided by Insurance Company for Dependent  
 Medical  Prescription Drug  Chiropractic  Dental  Vision

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NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female Full Time Student:  Yes  No  
Relationship to You \_\_\_\_\_ Employed  Yes  No Name of Employer \_\_\_\_\_ Employer Tel. # \_\_\_\_\_  
Name of Insurance Carrier \_\_\_\_\_ Telephone # \_\_\_\_\_ Policy # \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Policy Holder's Relationship to Dependent \_\_\_\_\_  
Please check all coverages provided by Insurance Company for Dependent  
 Medical  Prescription Drug  Chiropractic  Dental  Vision

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NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female Full Time Student:  Yes  No  
Relationship to You \_\_\_\_\_ Employed  Yes  No Name of Employer \_\_\_\_\_ Employer Tel. # \_\_\_\_\_  
Name of Insurance Carrier \_\_\_\_\_ Telephone # \_\_\_\_\_ Policy No. \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Policy Holder's Relationship to Dependent \_\_\_\_\_  
Please check all coverages provided by Insurance Company for Dependent  
 Medical  Prescription Drug  Chiropractic  Dental  Vision

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NAME \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender:  Male  Female Full Time Student:  Yes  No  
Relationship to You \_\_\_\_\_ Employed  Yes  No Name of Employer \_\_\_\_\_ Employer Tel. # \_\_\_\_\_  
Name of Insurance Carrier \_\_\_\_\_ Telephone # \_\_\_\_\_ Policy No. \_\_\_\_\_  
Name of Policy Holder \_\_\_\_\_ Policy Holder's Relationship to Dependent \_\_\_\_\_  
Please check all coverages provided by Insurance Company for Dependent  
 Medical  Prescription Drug  Chiropractic  Dental  Vision

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