

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 # _____
<u>Marital/Relationship Status:</u>		E-Mail Address _____
<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 Effective Date _____

Medical Prescription Drug Chiropractic Dental Vision

DEPENDENT CHILDREN

NAME _____ Date of Birth _____ Gender: Male Female Marital Status _____

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 Presc. Drug Dental Vision

Address of Dependent if different than Member _____

Please use reverse side for additional dependents.

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DEPENDENT CHILDREN

NAME _____ Date of Birth _____ Gender: Male Female Marital Status _____
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 Presc. Drug Dental Vision
Address of Dependent if different than Member _____

NAME _____ Date of Birth _____ Gender: Male Female Marital Status _____
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 Pres. Drug Dental Vision
Address of Dependent if different than Member _____

NAME _____ Date of Birth _____ Gender: Male Female Marital Status _____
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 Presc. Drug Dental Vision
Address of Dependent if different than Member _____

NAME _____ Date of Birth _____ Gender: Male Female Marital Status _____
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 Presc. Drug Dental Vision
Address of Dependent if different than Member _____

NAME _____ Date of Birth _____ Gender: Male Female Marital Status _____
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 Pres. Drug Dental Vision
Address of Dependent if different than Member _____
