

Painters District Council No. 3 Trust Fund
3100 Broadway, Suite 805 Kansas City, Missouri 64111-2413
(816)756-3313 or toll free (866)756-3313

Dear Participant:

Each calendar year it is necessary to update our records for this office. Please provide us with 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(s) 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	Soc. Sec. #	Employer/Other Insurance

If any of the above information changes during the calendar year, you must advise us immediately. (See back of 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

Sincerely,
 Benefits Administrator

