ADMINSTRATION OFFICE
CARPENTERS HEALTH FUND OF WEST VIRGINIA
3150 US ROUTE 60 * ONA, WV 25545 * (304) 525-0331

COVID-19 SPECIAL CONTINUATION OF COVERAGE APPLICATION

Please complete this form in INK, sign, and return it to this office, at the address noted above. This application is only valid to be submitted between April 17, 2020 through June 30, 2020.

Employee Social Security No.	Employee Last Name	Employee First Name	M.I.

Home Phone Number ( )	Street Address	City, State, Zip Code

Sex ( ) M ( ) F	Date of Birth	Marital Status	Local Union No.

Employer Name

Employer Address	Employer Phone Number

REQUIREMENTS. Please select one of the options below that pertain to your situation. Please remember to provide any documentation requested when submitting this application.

1. As of the date of your application, please confirm you are a participant with active coverage through work hours, utilization of bank hours, or self-pay. **Note - Retirees or individuals who do not have eligiblity under the Fund as of the date of their application would not meet this requirement.*

☐ Yes
☐ No

2. As of the date of this application, please confirm you are registered on an out-of-work list or have otherwise substantiated you are able to return to work to the satisfaction of the Union.

☐ Yes
☐ No

Specify:_____
_____**.** *(Please attached any documenation necessary, and you can use the back of this form for additional space.)*

3. I have provided one or more of the following forms of documentation (check which apply):

☐ a. A doctor's statement, on letterhead, showing a COVID-19 diagnosis for yourself or a member of your household.

Name	Relationship	Diagnosis Date

☐ b. A letter from your contractor, on letterhead, stating your job was shutdown, delayed or terminated because of COVID-19.

Employer

☐ c. A letter from your contractor, on letterhead, stating your job is not going forward because of COVID-19.

Employer

Employee Signature	Date

Office Use Only: **Approval:** ☐ **Yes** ☐ **No**

Note:

Member's Last Work Period Remitted:_____
Employer Name:_____
Member's Coverage Termination Date:_____

Committee Signature:_____ Date:_____

COVERAGE UPDATE
Date:_____

Elig Month:_____

TA/MGR:_____

*Please return this application and any necessary documentation to the address above or email: carpentersCOVIDapp@abchldg.com