CONSTRUCTION
INDUSTRY LABORERS
FRINGE BENEFIT FUNDS
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Kansas City, MO 64190
(816) 777-2669
(833) 479-9429 (toll free)
(816) 756-3659 (fax)

Managed for the Trustees by
Wilson-McShane Corporation

GKC Onboarding Retiree Vision and Dental Election Form

Please complete the front and back of this form, sign at the bottom of the last page and return. This form can be Emailed to CIL-Eligibility@wilson-mcshane.com or faxed to the contact information listed above. **You will have until Friday, December 15th to make your election. You will not be able to change your plan after that date.**

Participant Information

Last Name ______________________ First Name ______________________ Middle Initial ________

Social Security Number ______________________ Birth Date (MM/DD/YYYY) ____________ (______) ______________ Area Code Phone Number

Home Address ____ Apartment Number

City ______________________ State ______ Zip Code __________ Email Address ______________________

Check One: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced: ______________________
Date of Divorce (MM/DD/YYYY)

Dependent Information

List all eligible dependents to be covered. Additional documents may be requested.

Relationship (Spouse, Son, Stepdaughter)	Social Security Number	Last Name	First Name and Middle Initial	Date of Birth (MM/DD/YYYY)	Does this person have other group vision or dental coverage?
Spouse: ☐ M ☐ F					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No

Note: This form MUST be signed and dated on page 2 to be valid

Declaration of Other Coverage

Please complete for the Participant and each dependent that has any other group vision or dental coverage. Attach a separate sheet if necessary. Submit a copy of card(s) for each carrier.

Other Policy #1

Policy Holder:______________________ Policy or Group Number: ______________________

Policy Holder's Social Security Number:______________________ Does the plan cover dependents? ❑ Yes ❑ No

Plan Name:______________________ Employer's Name: ______________________

Plan Address:______________________ Plan Phone Number: ______________________

Status for Plan Coverage: ❑ Active ❑ Retired Follows Birthday Rule*: ❑ Yes ❑ No

Effective Date of Coverage:______________________ Termination Date: ______________________

Benefits Provided:

Dental: ❑ Yes ❑ No Vision: ❑ Yes ❑ No

Other Policy #2

Policy Holder:______________________ Policy or Group Number: ______________________

Policy Holder's Social Security Number:______________________ Does the plan cover dependents? ❑ Yes ❑ No

Plan Name:______________________ Employer's Name: ______________________

Plan Address:______________________ Plan Phone Number: ______________________

Status for Plan Coverage: ❑ Active ❑ Retired Follows Birthday Rule*: ❑ Yes ❑ No

Effective Date of Coverage:______________________ Termination Date: ______________________

Benefits Provided:

Dental: ❑ Yes ❑ No Vision: ❑ Yes ❑ No

* The birthday rule is a coordination of benefits rule that some plans use to determine which coverage is primary.

Retiree Vision and Dental Self Payment Rates

The rates below are a monthly self-payment rate charged by the Fund. Please complete the form if you wish to elect vision and/or dental coverage for you and your eligible dependents, if applicable, for coverage effective January 1, 2024. **You will have until Friday, December 15th to make your election. You will not be able to change your plan after that date.**

Dental and Vision Networks:

The CIL Plan has a dental contract with Connection Dental. With hundreds of general and specialist dentists participating in the network, finding a dental provider near you is easy. Connection Dental Network covers a 32-county service area including the Greater Kansas City Metropolitan Area and surrounding counties. Visit Connection Dental to find a provider, https://www.connectiondental.com/

The CIL Plan does not utilize a vision network for services. The CIL Plan does offer vision coverage.

Please refer to the SMM or the CIL Website, https://www.cilfunds.com/ for more information regarding benefits.

Benefit Type	**Rate**
Vision (Composite)	$7.00
Dental (Single)	$16.00
Dental (Member and Spouse)	$32.00
Dental (Family)	$54.00

By checking boxes I/We elect:

❑ **Vision Coverage**

❑ **Dental Coverage**

______________________ ______________________

Participant's Signature Date