

Coordination of Benefits

Member's Name: _____ Member ID #: _____ Date of Birth: _____

Address: _____

If you and/or spouse/dependents DO NOT have any other insurance coverage, please check this box turn over and sign/date the bottom of the next page (under "Member Statement").

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

A

MEMBER HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Medical/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Dental Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Vision Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? Age Disability ESRD

Part: A B C D Effective Date: A) _____ B) _____ C) _____ D) _____

B

SPOUSE AND DEPENDENTS HEALTH COVERAGE INFORMATION

Does this plan include **Medical** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Medical/Rx Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Dental** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Dental Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Does this plan include **Vision** Coverage? Yes or No If yes, is this plan an: HMO or PPO

Name of Vision Carrier: _____ Policyholder name: _____ Policy Number: _____

Effective Date: _____ Termination Date (if applicable): _____ Group Number: _____

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? Age Disability ESRD

Part: A B C D Effective Date: A) _____ B) _____ C) _____ D) _____

1.) Dependent: _____

Medical/Rx Effective Date: _____ **Dental** Effective Date: _____ **Vision** Effective Date: _____

• Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

2.) Dependent: _____

Medical/Rx Effective Date: _____ **Dental** Effective Date: _____ **Vision** Effective Date: _____

• Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

Continuation on other Side

For additional dependents, ATTACH A SEPARATE sheet with employee's name at top. (Last, First, MI)

3.) Dependent: _____

Medical/Rx Effective Date: _____ **Dental** Effective Date: _____ **Vision** Effective Date: _____

• Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

4.) Dependent: _____

Medical Effective Date: _____ **Dental** Effective Date: _____ **Vision** Effective Date: _____

• Name of **Medical/Rx** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Dental** Carrier: _____ Policyholder name: _____ Policy Number: _____

• Name of **Vision** Carrier: _____ Policyholder name: _____ Policy Number: _____

C

FILL OUT THIS SECTION ONLY IF YOUR CHILD(REN) HAVE ADDITIONAL HEALTHCARE COVERAGE DUE TO •DIVORCE •SEPARATION •COURT ORDER •MEDICARE OR •OTHER FEDERAL-STATE HEALTH INSURANCE PROGRAMS.

*****(Indicate which child by marking appropriate circle)** ***

1.) Is child(ren) covered by Medicare or other Federal-State coverage? Yes or No (If yes which child)? 1 2 3 4

Medicare: Policyholder name: _____ Policy Number: _____

Is coverage because of? Age Disability ESRD

Part: A B C D Effective Date: A) _____ B) _____ C) _____ D) _____

Medi-Cal/Medicaid: Policyholder name: _____ Policy Number: _____

2.) Does one parent/guardian have full custody of the child(ren): Yes or No (If yes which child)? 1 2 3 4

Parent: _____ **Date:** _____

3.) Is one parent required by court decree to provide health insurance for child(ren): Yes or No 1 2 3 4

Parent: _____ **Date:** _____

Name of person responsible for child's healthcare coverage? _____

Employer: _____ Date of Birth: _____

Insurance Company name: _____ Insurance Company City & State: _____

Insurance Company Phone Number: _____ Enrollee ID/ policy number: _____

Group Number: _____ Effective date: _____ Cancellation date (if applicable): _____

******If court decree is present please PROVIDE A COPY of the court documents ******

Member Statement: The above information is true and accurate to the best of my knowledge and belief. I am also aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage. Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers because of such material in any matter.

Signature: _____ **Phone #:** _____ **Date:** _____