

# 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:** \_\_\_\_\_