*******IMPORTANT******

Welfare Fund Coordination of Benefits

Dear Participant:

The following page of this Notice **must be completed and returned** to the Benefit Office. This information is necessary to determine if your spouse or any of your dependents are eligible for coverage other than through the Operating Engineers Local 513 Health Benefits.

This information is required in order for any claims that may have been received and are pending to be considered for processing. Claim payment will not be released until Coordination of Benefits is confirmed.

Please feel free to call if you have any questions.

Sincerely,

Operating Engineers Local 513 Fringe Benefit Fund

COORDINATION OF BENEFITS INQUIRY

A. General Information

Participant's Name:_____ Participant's SS#_____

Spouse's Name: _____ Spouse's D.O.B. _____

B. Spouse Employment Information:

Is Spouse employed? YES _____ NO _____ (If no, please skip to section C)

Does Spouse have insurance coverage through employer? YES _____ NO _____
(*If yes, this section must be completed).*

Spouse's Employer: _____

Employer's Address & Phone #:_____

Other Insurance Name: _____

Address: _____

City: _____ State:_____ ZIP Code:_____

Insurance Co. Phone #: (_____) _____

Policy/Group Number: _____

Effective date of coverage: _____Is insurance active: _____

Termination date if applicable: _____

Coverage is (circle) Single Family

Type of coverage *(circle all that apply)* Medical Dental Vision Prescription

List covered dependents:

_____ _____
_____ _____
_____ _____
_____ _____

C. Dependent(s) Employment Information: please provide information for each Dependent

Is Dependent(s) employed? YES_____ NO _____
Is Dependent married? YES_____ NO _____

Does Dependent(s) have insurance coverage through employer or spouse's employer? YES _____ NO _____
(*If yes, this section must be completed).*

Dependent or Spouse's Employer: _____

Employer's Address & Phone #:_____

Other Insurance Name: _____

Address: _____

City: _____ State:_____ ZIP Code:_____

Insurance Co. Phone #: (_____) _____

Policy/Group Number: _____

Effective Date of Coverage: _____ Is Insurance Active: YES_____NO _____

Termination Date, if applicable: _____

Type of coverage *(circle all that apply)* Medical Dental Vision Prescription

D. Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am 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 as a result of such material in any matter.

I Have No Other Insurance: _____
Initial Here/Sign Below

Participant's Signature:_____ **Date:**_____