

Coordination of Benefits

☐ If you and/or your dependents **DO NOT** have any other insurance coverage, please check this box and sign/date at the bottom of the page under "Member Statement" (section E)

Member Information: Name: _____ SSN or ID: _____

Other Insured Person (Policy Holder):

Name: _____ Date of Birth: _____ Relationship to Member: _____

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

OTHER HEALTH COVERAGE INFORMATION

A	Does this plan include Medical Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> PPO	
	Name of Medical Carrier: _____	Phone#: _____
	Effective Date: _____	Policy/Group Number: _____
B	Does this plan include Dental Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> PPO	
	Name of Dental Carrier: _____	Phone#: _____
	Effective Date: _____	Policy/Group Number: _____
C	Does this plan include Vision Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> PPO	
	Name of Vision Carrier: _____	Phone#: _____
	Effective Date: _____	Policy/Group Number: _____
D	Does this plan include Prescription Coverage? <input type="checkbox"/> Yes or <input type="checkbox"/> No If yes, is this plan an: <input type="checkbox"/> HMO or <input type="checkbox"/> PPO	
	Name of Prescription Carrier: _____	Phone#: _____
	Effective Date: _____	Policy/Group Number: _____

Fill out this section only if your children have health care coverage in addition to the above because of divorce, separation, court order or marriage work related group coverage.

Is there a court order that determines responsibility for health care coverage or custody? ☐ Yes or ☐ No

If yes, attach a copy of the sections that apply to health care responsibility and/or custody arrangements

Name of person responsible for child's health care coverage?		Employer	Birthdate
Insurance company name	Insurance company city	State	Phone number
Enrollee ID/policy number	Group number	Effective date	Cancellation date (if applicable)

List all covered dependents:

1. _____	Social Security#: _____ - _____ - _____
2. _____	Social Security#: _____ - _____ - _____
3. _____	Social Security#: _____ - _____ - _____
4. _____	Social Security#: _____ - _____ - _____
5. _____	Social Security#: _____ - _____ - _____

Custody Insurance: 1. Are you divorced or separated from the parent of any dependent on this policy listed above? ☐ Yes or ☐ No

• If Yes (continue) If No (skip to section E) ***** (Indicate which child by marking appropriate circle) *****

2. Does one parent/guardian have full custody of the child(ren)? ☐ Yes or ☐ No (If yes, which child)? ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

• Parent: _____ Date: _____

3. Is one parent required by court decree to provide health insurance for the children? ☐ Yes or ☐ No ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

• Parent: _____ Date: _____

****** If court decree is present, please provide an ATTACHMENT to the back of this copy ******

Medicare/Medicaid (if applicable)	Are you or anyone else on your policy covered by Medicare or Medicaid? <input type="checkbox"/> Yes or <input type="checkbox"/> No	Medicare Policy holder name	Medicare HIC number
Is the covered person retired? <input type="checkbox"/> Yes or <input type="checkbox"/> No		Is the Medicare coverage because of? <input type="checkbox"/> Age or <input type="checkbox"/> Disability	

****** Medicare coverage includes: (check all that apply, followed by effective date) ******

Type: A ☐ B ☐ C ☐ D ☐ Effective date: A) _____ B) _____ C) _____ 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.

E Signature _____	Telephone Number: _____	Date: _____
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