COORDINATION OF BENEFITS INQUIRY FORM

MEMBER NAME: _____

MEMBER ID #: _____

Your benefit plan contains a Coordination of Benefits (COB) provision. This form is required by Local 371 AWTF in order for us to process your claims accurately. If you have any additional questions regarding this questionnaire or if the information below changes, please call the Fund Office at 1-203-226-4217.

OTHER INSURANCE: CALENDAR YEAR 2018

Are you or any other member of the plan covered by another medical, dental insurance or vision policy?

☐ No - If *No*, please complete Section D, sign, date and return this form to Local 371 AWTF indicating "No other insurance." If previous coverage ended you must send a letter showing date coverage ended

☐ Yes - If *Yes*, please complete all the fields below that pertain to the member(s) that has other Coverage and return this form to Local 371 AWTF.

Section A *Please send a copy of your ID cards from other insurance*

Check those that apply:

☐ Health Insurance ☐ Dental Insurance ☐ Vision Insurance ☐ Prescription Coverage

What type of policy is this? ☐ Group ☐ Individual Policy ☐ Retirement Policy ☐ Medicare Supplemental

Other Insurance Carrier's Name: _____

Address: _____

City, State, Zip: _____

Dependent(s) listed on the other insurance: Effective or Cancel Date, if different from policyholder:

_____ ____/____/_____

_____ ____/____/_____

_____ ____/____/_____

Other Insurance Policyholder's Name: _____

Policyholder's Date of Birth: ____/____/_____ ID # _____

Effective Date of Other Insurance: ____/____/_____ If Cancelled, Cancellation Date: ____/____/_____

Is the policyholder:

☐ Actively working ☐ Inactive

☐ Retired, retirement date: ____/____/_____ COBRA, which began: ____/____/_____

Policyholder's Employer: _____

Employer's Address: _____

City, State, & Zip: _____

Section B *If this does not apply answer no and skip to Section C.*

MEDICARE INFORMATION

Do the policyholder and/or dependent(s) have Medicare? ☐ Yes ☐ No

Name of person(s) with Medicare: _____

Medicare Number, including alpha character(s): _____

Effective Date of Medicare Part A: ____/____/_____ Effective date of Medicare Part B: ____/____/_____

Effective Date of Medicare Part D: ____/____/_____

Medicare Entitlement: ☐ Age ☐ Disability* ☐ End Stage Renal Disease (ESRD)* *

If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability: ____/____/_____

1st Date of Dialysis for ESRD: ____/____/_____

Was ESRD started in a facility? ☐ Yes ☐ No

Was ESRD started as Self Dialysis or Home Dialysis: ☐ Yes ☐ No

Has a transplant been performed? ☐ Yes ☐ No

If Yes, please provide the date of the transplant. ____/____/_____

Section C *If this does not apply select no and skip to Section D.*

COURT ORDER INFORMATION

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ No ☐ Yes

List the name(s) of the dependent(s) that this applies to _____

If Yes, who is the person(s) listed to maintain health coverage? _____

What is the relation to the child(ren)? _____

Who has custody of the child(ren) more than 50% of the time? _____

Documentation of the court order must be provided to Local 371 AWTF.

Policyholder Signature: _____ **Date:** ____/____/_____