Coordination of Benefits Questionnaire

This questionnaire helps us to coordinate your benefits with other health insurance you may have.
Your response will help us to ensure claims are processed properly according to your health benefits plan.

If we do not receive the completed questionnaire, your spouse's benefits will be suspended.
If you have any questions, please contact the Fund office at 610-489-1185. Thank you for your cooperation in completing this questionnaire.

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1. Print Name: _____
2. Member ID number: _____
3. I am covered under another health plan. ❑ Yes ❑ No
4. My spouse/dependents are covered under another health plan. ❑ Yes ❑ No

   If the answer to question 3 or 4 is "Yes," please attach a copy of your insurance ID card and complete the following about the other plan:

Employer Name/Plan Name		Employment Status	❑ Active ❑ Retired	
Insurance Company Name				
ID#/Policy #		Phone Number		
Type of Coverage (*select all that apply*)	❑ Hospital ❑ Doctor ❑ Dental ❑ Vision ❑ Drug ❑ Medicare			
	Name	Birth Date	Effective Date*	Termination Date
Plan Member				
Spouse				
Dependent**				
Dependent				
Dependent				
Dependent				

5. I am, or one of my dependents is, enrolled in Medicare. ❑ Yes ❑ No

   If you answered "Yes" to question 5, please include a copy of the ID card and write the reason for entitlement here (for example: age, disability, dialysis): _____

6. Please provide a daytime phone number in case we need to contact you: _____

_____ _____
Signature Date

* Please specify the appropriate effective date for each member if it differs from the Plan Member's effective date.
** To add more dependents, please attach an additional sheet of paper.

Please complete and return this questionnaire to:
LOCAL UNION 126 HEALTH AND WELFARE FUND
3455 GERMANTOWN PIKE
COLLEGEVILLE, PA 19426

or fax to: 610-489-6988