

Coordination of Benefits Form - 2021

Your insurance with Sheet Metal Workers' Local 73 Welfare Fund contains a Coordination of Benefits provision. Processing of claims submitted under your contract depends upon your response.

Section #1 - Information about You

Member's Name: _____ Soc. Sec. No.: _____
 (Last) (First) (M.I.)
 Home Address: _____ City: _____ State: _____ Zip: _____
 Home Phone Number: _____ Cell Phone Number: _____
 Email Address: _____

Section #2 - Information about Your Spouse

Name (first, initial, last): _____ Date of Birth: _____ Social Security Number: _____
 Employer: _____ Employer's Telephone Number: _____
 Employer's Street Address: _____ City: _____ State: _____ Zip: _____

Section #3 - Other Insurance

Is your spouse employed? No Yes (If yes, complete employer information below.)
 Besides being covered by Sheet Metal Workers' Local 73 Welfare Fund, are you, your spouse or any other family member currently covered by any other plan (including group insurance, prescription drug, dental, vision, student or sports policies or Medicare)?
 No (If "No" complete Section 5 below) Yes (If "YES" complete Sections 4 and 5 below)

Section #4 - Other Insurance Information

Please indicate below the type of other insurance coverage you have by marking "YES" or "NO." If you answer "YES" please complete the area to the right of the box.

Type of Coverage:	Insurance Company or Carrier Name and Phone Number:	Policy Holder's Name and I.D. Number:	Effective Date and Termination Dates:	Who is Covered?
Medical <input type="checkbox"/> No <input type="checkbox"/> Yes	Carrier: _____ Phone: _____	Policy Holder's Name: _____ Policy I.D. #: _____	Effect. Date: _____ Term. Date: _____	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Pres. Drug <input type="checkbox"/> No <input type="checkbox"/> Yes	Carrier: _____ Phone: _____	Policy Holder's Name: _____ Policy I.D. #: _____	Effect. Date: _____ Term. Date: _____	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Dental <input type="checkbox"/> No <input type="checkbox"/> Yes	Carrier: _____ Phone: _____	Policy Holder's Name: _____ Policy I.D. #: _____	Effect. Date: _____ Term. Date: _____	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Vision <input type="checkbox"/> No <input type="checkbox"/> Yes	Carrier: _____ Phone: _____	Policy Holder's Name: _____ Policy I.D. #: _____	Effect. Date: _____ Term. Date: _____	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Medicare <input type="checkbox"/> No <input type="checkbox"/> Yes	(Not required for Medicare.)	Policy Holder's Name: _____ Policy I.D. #: _____	Effect. Date: _____ Term. Date: _____	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Other <input type="checkbox"/> No <input type="checkbox"/> Yes	Carrier: _____ Phone: _____	Policy Holder's Name: _____ Policy I.D. #: _____	Effect. Date: _____ Term. Date: _____	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children

Section #5. Sign and Date – Return Form to the Fund Office

X _____
 Member's Signature Date

Please return the form in the enclosed envelope or return to the address at the top of this form. It is your responsibility to inform the Fund Office of any changes which occur during the calendar year. Thank you.