LOCAL 15

A, C, D WELFARE FUND

Coordination of Benefits
Coverage Under More Than One
Insurance Program or Plan

Dear Plan Participant:

One of the major reasons for delays in claims processing is the need for correct and updated information to support the proper adjudication and timely payment of you and your eligible dependents medical, dental, vision and pharmaceutical claims. To that end, the Fund requires its participants to complete and return the Coordination of Benefits Form.

What is Coordination of Benefits?

Coordination of benefits (COB) applies to individuals who are covered by more than one health plan or health insurance carrier. The Welfare Fund's coordination of benefit (COB) provision requires it to coordinate benefits with other payers (e.g., your spouse's employer based insurance program, Medicare, Medicaid, even Workers' Compensation carriers) to eliminate duplication of payment and assist patients to receive the maximum benefit to which they are entitled.

Confused as to what constitutes other payers/insurers? Other possible payers could include, but is not limited to:

- Insurance policies maintained by you or your spouse.
- Other insurance still in effect at the time of enrollment. I.e., Other insurance from you or your prior Local or trade Union, or employer.
- No Fault or liability insurance
- Workers' Compensation for a specific injury, illness or disease.
- Medicare or Medicaid benefits.
- Medicare or Medicaid benefits related to renal failure, kidney disease or liver transplants or any other disability.
- Federal Black Lung Program
- COBRA continuation of coverage
- Employer group health plans
- Retiree group health plans
- Federal Employee Plans
- City Employee Plans
- Military coverage (VA and TRICARE For Life)
- NYS Workers' Compensation for Volunteers and Worker's involved in the September 11, 2001 rescue and recovery work.

By completing this form you are:

1. Assuring that your family's claims are paid correctly "the first time, every time."
2. Guaranteeing that you and your eligible dependents are in compliance with the provisions of the Plan.
3. Ensuring efficient service when you require it.
4. Protecting the Welfare Trust Fund.

STOP Everyone needs to complete this form. Each section needs to be completed, signed and dated. If the section is not applicable to you, check the appropriate box, sign and date that section. Remember to print clearly and return the completed forms to the address listed on the back of this document.

STOP If you do have other insurance, you are required to submit supporting records attesting to that coverage. Please refer to the section of this document titled "Supporting Documentation".

STOP Failure to complete this form in its entirety, could result in you and your dependent's inability to claim benefits from this Fund or the termination of coverage.

STOP The Welfare Fund will provide you with signed confirmation attesting to the receipt of this document. If you do not receive this verification, it means the Welfare Fund never received your Coordination of Benefits document.

Policy Holder Information

Social Security Number: _____

Name: _____
First Middle Last Suffix (Jr., II etc)

Date of Birth (Month/Day/Year)_____Sex: Male_____ Female_____

Marital Status (please circle): Single Married Divorced Widowed Separated

_____
Street Address Apt # City State Zip

Home Phone # _____ Cell # _____

E-Mail Address _____

I declare the information on this form is true and complete. I agree to provide additional documentation to confirm this information if requested by the Welfare Fund. I agree to immediately notify the Welfare Fund of any changes in this information and understand that if I fail to do so and receive or attempt to receive benefits, the Welfare Fund will consider that an act of fraud against the Plan. I fully understand that if this occurs the Welfare Fund may terminate my or my dependents benefits, withhold any other benefits that may be payable to me or my dependents, take legal action against me in order to recover administrative costs, legal fees, interest or any amounts paid, and notify the appropriate authorities about criminal proceeding's.

Signature: _____ Date:_____

Notice: Participants are reminded that:

1. They must notify the Fund Office in writing of any changes in or about other insurance coverage within sixty days from the occurrence of the event. This would include, but not limited to the addition/loss of any medical, dental, pharmaceutical, or vision benefits that were individually elected or gained/lost due to employment, marriage/divorce, State/Federal insurance programs or Court mandates.

2. To familiarize themselves with the Enrollment, Eligibility and Fraud provisions of this Plan, as they will be meticulously applied and enforced.

3. To familiarize themselves with the Coordination of Benefit provision of the plan, and if applicable, the section of the Welfare Funds Summary Plan Description book titled "Workers' Compensation".

4. The Welfare Fund reserves the right to request its participants to complete this document from time to time and as often as it determines reasonably necessary in order to maintain correct information essential for the proper processing of claims.

For Participants Involved in the Rescue and Recovery Work on and/or after September 11, 2001

❑ I was involved in the Rescue and Recovery Work on and/or after September 11, 2001.

❑ I was not involved in the Rescue and Recovery Work on and/or after September 11, 2001.

Signed _____ Date: _____

For Participants who have filed a Workers' Compensation Claim Anytime During Their Working Careers (please print)

Please explain the type of injury, illness or disease that was caused in connection to your employment:

_____

_____

_____

When did this injury, illness or disease occur? _____

What was the initial date of coverage with this other insurance? _____

What is the name, address and phone number of the Workers' Compensation carrier handling your case or handled this case?

_____

_____

_____

❑ I have never filed a Workers' Compensation claim.

Signature _____ Date: _____

Information Concerning Other Insurance Program or Plan

(E.g., spouses insurance, former employer insurance, Medicare, Medicaid or another Trade Union Insurance. If you have more than one insurer, please check the item marked "multiple insurers" below and then add the additional insurance carrier's name, representative contact name and phone number, employer name (including address, & date of hire,) on an attached sheet. Print Clearly)

If no other insurer exists the participant must attest to that directly below.

❑ Neither I nor any of my eligible dependents have other insurance.

Signature _____ Date: _____
(Member/Participants Signature)

If other insurance's exist, the information pertaining solely to the other health insurance coverage/ policy and its policy holder needs to be disclosed to the Fund in the area below.

❑ Multiple Insurers

Social Security Number: _____

Name: _____
First Middle Last Suffix (Jr., II etc)

Date of Birth (Month/Day/Year)_____

Name and Address of Other Insurance Program or Carrier:

_____

_____

Contact Phone Number of Other Insurance: _____

Policy Number for Other Insurance: _____

Is this coverage offered to you through your employer? (please circle) Yes No

What is the initial date of employment with this employer? _____

What is the name and address of your employer?

_____

_____

Please circle the type of benefits being covered: Medical Dental Vision Pharmaceutical

Is the insurance policy an individual policy or family policy? Individual Family

If it is a family plan, please circle the type of benefits being extended to your dependents:

Medical Dental Vision Pharmaceutical

What was the initial date of coverage with this other insurer? _____

Relation to Member/Participant who maintains I.U.O.E. Local 15 Welfare Fund coverage:

Spouse Child Other (please explain) _____

Signature _____ Date: _____
(Member/Participants Signature)

Supporting Documentation for Individuals with Other Insurance

Participants with other insurance will need to submit a copy of their insurance card, along with one of the following items.

1. Document of Credible Coverage from Other Insurance Provider.
2. Document from the Employers human resource department attesting to coverage.
3. Document from the Insurance carrier/company attesting to coverage.
4. Document attesting to coverage from a Branch of the Military.
5. A document from your Workers' Compensation Insurance Carrier attesting to a specific injury and coverage.
6. Letter from the Center of Medicare Services attesting to Medicare, Medicaid benefits and/or a copy of your Social Security Award.

For Office Use Only

Date Received: _____ Date Entered: _____

Name of Individual Entering Information: _____

Date Mailed Back to Participant: _____

Form Was Deemed: ❑ Complete ❑ Incomplete

Missing Information in "Policy Holder Information" Section (Page 3): ❑ Yes ❑ No

Missing Information in "September 11, 2001" Section (Page 4): ❑ Yes ❑ No

Missing Information in "Workers' Compensation" Section (Page 4): ❑ Yes ❑ No

Missing information concerning other insurance program or plan (Page 5): ❑ Yes ❑ No

Comments: _____

_____

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_____

Signed: _____ Date: _____