



INDIANA LABORERS WELFARE FUND
 PO BOX 1587
 TERRE HAUTE, IN 47808
 Phone: (812) 238-2551 | Fax: (812) 238-1563
 www.indianalaborers.org

Dependent Custody Form

The medical coverage with the Indiana Laborers Welfare Fund contains a Coordination of Benefits (COB) provision.
Failure to complete and return will result in non-payment of claims.

Participant Name:		ID# or SSN:	
Child's Name:			
Child's Date of Birth:	With whom does the child reside?	Relationship with who the child resides?	
Child's Home Address:	City & State:	Zip Code:	
Natural Father's Name:			
Natural Mother's Name:			
Step-Parent's Name:			
Step-Parent's Name:			
Is there a Court Order (Divorce Decree, Settlement Agreement, Custody or Medical Support Documentation, etc.) specifying a person(s) to maintain health coverage for the above listed child?		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Documentation of the Court Order MUST be included with this form.			
Does the child listed above have any OTHER insurance coverage:		<input type="checkbox"/> Yes	<input type="checkbox"/> No
If you answered "Yes" complete the section below and submit a copy of the front and back of your other insurance card with this form.			
Insurance Policy Information			
Policy Holder's Name:		Policy Holder's Date of Birth:	
Name of Plan:	Member ID or Policy Number:	Customer Service Phone Number of Plan:	
Effective Date:	Type of coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family	Please check all that apply: <input type="checkbox"/> Medical <input type="checkbox"/> Prescription <input type="checkbox"/> Vision <input type="checkbox"/> Dental	
Additional Insurance Policy Information if applicable			
Policy Holder's Name:		Policy Holder's Date of Birth:	
Name of Plan:	Member ID or Policy Number:	Customer Service Phone Number of Plan:	
Effective Date:	Type of coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family	Please check all that apply: <input type="checkbox"/> Medical <input type="checkbox"/> Prescription <input type="checkbox"/> Vision <input type="checkbox"/> Dental	

I hereby certify that all of the above statements are true, complete and accurate. I understand that if this information changes, it is my responsibility to notify the Indiana Laborers Welfare Fund Office immediately. I understand that I will be required to reimburse the Indiana Laborers Welfare Fund for any payments made as a result of my failure to notify of a change in the information on this Coordination of Benefits Form.

Participant Signature: _____

Date: _____