INDIANA LABORERS WELFARE FUND

PO BOX 1587
TERRE HAUTE, IN 47808
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www.indianalaborers.org

COORDINATION OF BENEFITS (COB) and VERIFICATION FORM

This form is required to be completed. **Failure to complete and return will result in non-payment of claims.**

NAME	**RELATION**	**DATE OF BIRTH**	**PHONE #**

1. Should anyone listed above be removed due to divorce or court order?

   Yes   No

   If you answered "Yes," please specify who and submit a copy of the divorce decree or court order.

   _____

2. Should anyone be included in your health benefit plan who is **NOT** listed above?

   Yes   No

   If you answered "Yes," please contact the Fund Office.

COMPLETE BOTH SIDES OF THIS FORM

3. Is anyone listed above covered by any other medical/dental/prescription or vision plan?

    Yes   No

    If you answered "Yes," a copy of the front and back of all other carriers' benefit card(s) is required.

4. Is anyone listed above covered by Traditional Medicare or a Medicare Advantage Plan?

    Yes   No

    If you answered "Yes," a copy of the Medicare card(s) is required.

5. Has anyone listed above been awarded Social Security disability benefits?

    Yes   No

    If you answered "Yes," please specify who below and submit a copy of the Social Security disability award letter.

_____

I hereby certify that all information provided is correct. I understand that if this information changes, it is my responsibility to notify the Indiana Laborers Welfare Fund Office immediately. I also 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 and Verification Form.

_____   _____
Participant Signature   Date

_____   _____
Spouse Signature   Date

Access to your benefits is available 24/7 on the Member Portal. If you haven't already created a Member Portal Account, scan the QR code to get started!

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