

**INDIANA LABORERS WELFARE FUND**

PO BOX 1587

TERRE HAUTE, IN 47808

Phone: (812) 238-2551 | Fax: (812) 238-2553

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.*

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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**

Alt ID:

Member Name:

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.*

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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.

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Participant Signature

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Date

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Spouse Signature

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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!

