INDIANA LABORERS WELFARE FUND
PO BOX 1587
TERRE HAUTE, IN 47808
Phone: (812) 238-2551 | Fax: (812) 238-2553
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 to child:
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? ☐ Yes ☐ No **Documentation of the Court Order MUST be included with this form.**		
Does the child listed above have any OTHER insurance coverage: ☐ Yes ☐ 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: ☐ Single ☐ Family	**Please check all that apply:** ☐ Medical ☐ Prescription ☐ Vision ☐ 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: ☐ Single ☐ Family	**Please check all that apply:** ☐ Medical ☐ Prescription ☐ Vision ☐ 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: _____