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

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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