# Health and Benefit Trust Fund
of the
# International Union of Operating Engineers
# Local 94, 94A, 94B




331-337 West 44th Street
New York, NY 10036

**WILLIAM FARANDA**
Executive Director

**KATHRYN M. FISLER**
Administrator




## Coordination of Benefits Form

**Participant's Name: _____ Social Security No. _____**
**(PLEASE PRINT CLEARLY IN ALL SECTIONS)**

### SECTION 1

**Is spouse covered for health insurance and/or medical benefits? ❒ YES ❒ NO (if checked, skip to Section 2)**

**Actively Working: Yes _____ No _____ Retired: *Yes _____ No _____**
***If yes, please provide the effective date of coverage as a Retiree.**

**Spouse's Employer's Name:** _____

**Address:** _____

**Spouse's Job Title/Position:** _____

**Supervisor's Name:** _____ **Phone Number:** _____

**Name of Insured:** _____ **Date of Birth:** _____

**Name and address of Insurance Company/Union through which coverage is provided:**

**Name of Insurance Company/Union:** _____

**Address:** _____

**Effective Date of Coverage:** _____ **ID#:** _____ **Individual Coverage ❒** **Family Coverage ❒**

**Group Number:** _____

**Coverage Includes: Hospital ❒ Medical ❒ Dental ❒ Prescription ❒ Eye Care ❒**

**When health coverage is available to dependent children through more than one parent, Coordination of Benefit rules apply. The plan that covers the parent whose birthday falls earlier in the calendar year is primary (month & day only, not year).**

### SECTION 2

**Is Dependent covered for health insurance and/or medical benefits? ❒ YES ❒ NO (if checked, skip to Section 3)**

**Dependent's Employer's Name:** _____

**Address:** _____

**Dependent's Job Title/Position:** _____

**Supervisor's Name:** _____ **Phone Number:** _____

**Name of Insured:** _____ **Date of Birth:** _____
**(Dependent Child)**

## SECTION 2 (CONTINUED)

**Name and address of Insurance Company/Union through which coverage is provided:**

**Name of Insurance Company/Union:** _____

**Address:** _____

**Effective Date of Coverage:**_____ **ID#:**_____ **Individual Coverage ❒** **Family Coverage ❒**

**Group Number:** _____

**Coverage Includes: Hospital ❒ Medical ❒ Dental ❒ Prescription ❒ Eye Care ❒**

## SECTION 3

**Is Dependent child covered under a policy and the parents are divorced, legally separated or a biological parent of the dependent child?**
**❒ YES ❒ NO (if checked, skip to Section 4)**

**Name of Insured:** _____ **Date of Birth:** _____
**(Parent: Divorced, Legally Separated or Biological Parent)**

**Name and address of Insurance Company/Union through which coverage is provided:**
**(Parent: Divorced, Legally Separated or Biological Parent)**

_____

_____

_____

**Effective Date of Coverage:**_____ **ID#:**_____ **Individual Coverage ❒** **Family Coverage ❒**

**Group Number:** _____

**Coverage Includes: Hospital ❒ Medical ❒ Dental ❒ Prescription ❒ Eye Care ❒**

**When health coverage is available to dependent children through employment the child's plan that covers the child as an employee pays first. Next the plan that covers the child as a dependent pays second. Secondly the parent's plan of a dependent child whose birthday falls earlier in the calendar year (month & day only, not year) pays first.**

## SECTION 4

**If your spouse or a parent of dependent child, or the dependent child's coverage ends for any reason, the Fund Office will need a letter from the employer or health care carrier stating the date coverage terminated.**

**I agree to provide Coordination of Benefits information to the Fund and if any claims are processed and paid by the Fund for which my eligible dependents has or had coverage which would be considered primary, I will be responsible to reimburse the Fund for any and all such claims.**

_____ _____

**Participant's Signature** **Date**