## Health and Benefit Trust Fund

of the

# International Union of Operating Engineers Local 94, 94A, 94B

**EMPLOYER TRUSTEES** 

HOWARD ROTHSCHILD THOMAS HILL ROBERT SCHWARTZ STEPHEN BRENNAN 331-337 West 44<sup>th</sup> Street New York, NY 10036

#### WILLIAM FARANDA

**Executive Director** 

### DEREK J. DAVIS

Administrator

#### **UNION TRUSTEES**

KUBA J. BROWN THOMAS M. HART, JR. MICHAEL GADALETA RAYMOND J. MACCO

#### **Coordination of Benefits Form**

	/DI 54		Social Security No		
	(PLEA	SE PRINT CLEARLY I	-		
		SECTION	1		
Is spouse covered for health insur	rance and/or medica	al benefits?   YES	NO (if checked, sl	tip to Sect	ion 2)
Actively Working: Yes	No		Yesease provide the effecti		 f coverage as a Retire
Spouse's Employer's Name:					
Address:					
Spouse's Job Title/Position:					
Supervisor's Name:	Phone Number:				
Name of Insured:	Date of Birth:				
Name of Insurance Company/Unio					
			Individu	al	Family
Effective Date				_	Coverage
	ID#:		Coverag	e 🗇	Coverage L
of Coverage:			Coverag	e 🛘	Coverage D
of Coverage:		Dental 🗆	Coverag  Prescription	e □ Eye Ca	·
of Coverage:  Group Number:  Coverage Includes: Hospital	Medical ☐ e to dependent child	Dental ☐ Iren through more t	Prescription <b>☐</b> than one parent, Coord	Eye Ca	re □ Benefit rules apply.
of Coverage:  Group Number:  Coverage Includes: Hospital   When health coverage is available	Medical ☐ e to dependent child	Dental ☐ Iren through more t	Prescription   than one parent, Coord primary (month & day	Eye Ca	re □ Benefit rules apply.
of Coverage:  Group Number:  Coverage Includes: Hospital   When health coverage is available that covers the parent whose birtle	Medical □  e to dependent child thday falls earlier in t	Dental ☐ Iren through more t the calendar year is SECTION	Prescription   than one parent, Coord primary (month & day	Eye Ca ination of only, not	re   Benefit rules apply. year).
of Coverage:  Group Number:  Coverage Includes: Hospital  When health coverage is available that covers the parent whose birth	Medical   Medical   to dependent child  chday falls earlier in the  character in the	Dental  Iren through more the calendar year is  SECTION Edical benefits?	Prescription  than one parent, Coord primary (month & day 2 YES  NO (if checked	Eye Ca ination of only, not	re   Benefit rules apply. year).
of Coverage:  Group Number:  Coverage Includes: Hospital  When health coverage is available that covers the parent whose birtle  Is Dependent covered for health in Dependent's Employer's Name:	Medical   Medical   e to dependent child  thday falls earlier in the  insurance and/or me	Dental  dren through more to the calendar year is  SECTION  edical benefits?	Prescription  than one parent, Coord primary (month & day  2 YES  NO (if checked	Eye Ca ination of only, not	re   Benefit rules apply. year).
of Coverage:  Group Number:  Coverage Includes: Hospital  When health coverage is available that covers the parent whose birt!  Is Dependent covered for health in Dependent's Employer's Name:	Medical   Medical   e to dependent child  thday falls earlier in the  insurance and/or me	Dental  dren through more to the calendar year is  SECTION  edical benefits?	Prescription  than one parent, Coord primary (month & day  YES  NO (if checked	Eye Ca ination of only, not	re   Benefit rules apply. year).
of Coverage:  Group Number:  Coverage Includes: Hospital  When health coverage is available that covers the parent whose birth  Is Dependent covered for health in Dependent's Employer's Name:  Address:	Medical   e to dependent child  thday falls earlier in the  insurance and/or me	Dental  Iren through more to the calendar year is  SECTION  edical benefits?	Prescription  than one parent, Coord primary (month & day  YES  NO (if checked	Eye Ca ination of only, not d, skip to	re   Benefit rules apply. year).

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## SECTION 2 (CONTINUED)

Name and address of Insurance Company/Union through which coverage is provided:							
Name of Insurance Company/Union: _							
Address:							
Effective Date		Individual	Family				
of Coverage:	ID#:	Coverage	Coverage				
Group Number:							
Coverage Includes: Hospital	Medical Dental Dental	Prescription	Eye Care 🗆				
	SECTION 3						
Is Dependent child covered under a pol YES NO (if checked, skip to Sect		egally separated or a b	iological parent of the dependent child?				
Name of Insured:	Date of Birth:		·				
(Parent: Divorced, Legally Separated or	Biological Parent)						
Name and address of Insurance Compa	ny/Union through which coverage	is provided:					
(Parent: Divorced, Legally Separated or	Biological Parent)						
Effective Date		Individual	Family				
of Coverage:	ID#:	Coverage 🗆	Coverage				
Group Number:							
Coverage Includes: Hospital	Medical Dental 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.							
	<b>SECTION 4</b>						
If your spouse or a parent of dependen from the employer or health care carrie		-	eason, the Fund Office will need a letter				
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	<del></del>		 Date				

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