

Coordination of Benefits Questionnaire



IUOE LOCAL 4 HEALTH & WELFARE PARTICIPANT NAME: _____

IUOE LOCAL 4 BLUE CROSS BLUE SHIELD ID # : UEF: _____

IUOE LOCAL 4 DELTA DENTAL ID # : _____

Your Health & Welfare Plan contains a Coordination of Benefits (COB) provision. When the Health & Welfare Plan pays secondary due to other insurance, the dollars you save the Plan help to hold down Plan costs. Savings from your medical claims are credited to a COB Savings Account as long as the Medical Plan receives information on what your primary Plan allowed and paid. Twenty five percent of that savings from medical claims can be reimbursed to you each year up to a maximum of \$600 per year per family. (Dental and Prescription claims are excluded from the COB Savings Account calculation). We depend upon your help in order to process your claims correctly and appreciate your prompt and accurate reply to this questionnaire. If you have any questions contact the Health & Welfare Fund Office at 1-888-486-3524.

OTHER INSURANCE: Are you or any of your dependents who are covered under this Health & Welfare Plan also covered by another medical or dental insurance policy or were covered by such a policy during the past two years?

NO, there is no other insurance. If *No*, please sign and date here and return in the self addressed envelope

PRINT NAME

SIGNATURE

DATE

NO, our prior coverage cancelled. List effective date of cancellation and attach HIPAA Certificate from prior insurer _____

OTHER INSURANCE CANCELLATION DATE

HIPAA CERTIFICATE ENCLOSED

PRINT NAME

SIGNATURE

DATE

YES, If *Yes*, please complete all the fields below that pertain to the participant(s) that has the other coverage.

Section A

Other Insurance Policyholder's Name: _____ Effective Date of Other Insurance _____

Other Medical ID _____ Other Dental ID _____

Other Medical Insurance Carrier's Name: _____

Other Dental Insurance Carrier's Name: _____:

Dependent(s) covered on the other insurance: _____

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Are above policies due to eligibility for Medicare or Medicaid/Mass Health? Yes No

Entitlement Reason: Age Disability End Stage Renal Disease (ESRD) Other

Section B

COURT ORDER INFORMATION

Is there a Court Order specifying a person to maintain health coverage for any of your dependent(s)?

No Yes List the name(s) of dependent(s) this applies to. _____ f
Who is the person listed to maintain health coverage? _____

Documentation of the court order may be requested from the Fund Office

Participant Signature: _____ Date: ____/____/____

IUOE Local 4 Benefit Fund Office PO Box 660 Medway, MA 02053-0660