

Coordination of Benefits Questionnaire



IUOE LOCAL 4 HEALTH & WELFARE PARTICIPANT NAME: _____

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

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 are credited to a COB Savings Account. Twenty five percent of that savings (from PPO and Indemnity Plans) is reimbursed to you each year up to a maximum of \$600 per year. 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?

No If *No*, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

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

Section A *If this does not apply, skip to Section B.*

Other Insurance Policyholder's Name: _____

Policyholder's Date of Birth: ____/____/____ ID # with Other Insurance _____

Check all that apply:

Other Medical Insurance PPO____HMO____ Indemnity Plan____ Other Dental Insurance

What type of policy is this?

Group Individual Policy Student Policy Medicare Supplemental

Other Insurance Carrier's Name: _____

Address: _____ City, State, Zip: _____

Phone Number: _____

Dependent(s) listed on the other insurance: _____

Effective Date of Other Insurance: ____/____/____ If Cancelled, Cancellation Date: ____/____/____

Is the policyholder:

Actively working for the group Inactive Retired, retirement date: ____/____/____

On COBRA, which began: ____/____/____

Policyholder's Employer: _____

Employer's Address: _____ City, State, Zip: _____

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Section B *If this does not apply, skip to Section C.*

MEDICARE/MEDICAID INFORMATION

Does the participant and/or dependent(s) have Medicaid/Mass Health? Yes No

Does the participant and/or dependent(s) have Medicare? Yes No

Name of person(s) with Medicare: _____

Medicare Number, including alpha character(s): _____

Effective Date of Medicare A: ___/___/___/___ Effective date of Medicare B: ___/___/___/___

Effective Date of Medicare D: ___/___/___

Medicare Entitlement: Age Disability* End Stage Renal Disease (ESRD)*

* If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability: ___/___/___

1st Date of Dialysis for ESRD: ___/___/___

Was ESRD started in a facility? Yes No

Was ESRD started as Self Dialysis or Home Dialysis: Yes No

Has a transplant been performed? Yes No

If yes, please provide the date of the transplant. ___/___/___

Section C *If this does not apply, skip to Section D.*

COURT ORDER INFORMATION

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

No Yes

List the name(s) of the dependent(s) that this applies to. _____

If yes, who is the person(s) listed to maintain health coverage? _____

What is the relation to the child(ren)? _____

Who has custody of the child(ren) more than 50% of the time? _____

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

Section D

NAME(S) OF DEPENDENT(S) ON HEALTH & WELFARE PLAN (attach additional sheet if necessary)

Name	Relationship	Date of Birth	Sex

Participant Signature: _____ Date: ___/___/___

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