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 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:__________________________

Coordination of Benefits Questionnaire

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: ____/____/______

Local 4 Benefit Fund Office . 16 Trotter Drive . Medway, MA 02053-2299