ANNUAL COORDINATION OF BENEFITS FORM

Tuckpointers Local 52 Health & Welfare
660 Industrial Drive, Suite 201
Elmhurst, IL 60126
(630) 516-8008

You and other members of your household may be covered by more than one health insurance or dental plan. Coordination of benefits is a way to coordinate your health and welfare benefits when dual coverage exists. Accurate information is needed annually to account for changes in your family member's employment status or coverage elections. With current information on file, your claims will not be unnecessarily delayed.

Note: Your primary coverage as the member is generally Local 52's plan. Coverage under your spouse's employer is generally primary for your spouse and secondary for you. If you have eligible dependent children covered by dual plans, the coverage of the parent whose birthday falls first in the calendar year is generally considered the primary plan and the coverage of the other parent is generally secondary. If you have any adult child with coverage through their own employer, that coverage is primary for the adult child.

Please take a few minutes to complete this form and return it to the Fund Office.

Member Name: _____ Social Security No. XXX XX _____
First Name Middle Name Last Name

Address: _____
Street Number and Name Apt. # City State Zip Code

Phone Number: _____ Alternate Phone #_____ Date of Birth: _____

☐ **Our family has no health insurance other than Local 52's Health and Welfare Plan**

☐ **Our family or a family member has another plan (complete section below)**

Family Member with other Coverage: _____ Family Member Date of Birth: _____-_____-_____

☐ Employer ? _____ Yes _____ No ☐ Medicaid/State Aid _____ Yes _____ No
☐ County Care _____ Yes _____ No ☐ Medicare _____ Yes _____ No

Employer Name: _____

Employer's Insurance _____

Name of all family members covered by other insurance (state All if applicable)

Policyholder: Name _____ Date of Birth _____

_____

Type of Coverage: _____ **Medical** _____ **Dental** _____ **Vision**

Effective Date: _____ (With Copy of Insurance Card)

This form must be completed in full, signed and dated by the MEMBER.
I certify that all information included in this claim is correct. Any misrepresentation or fraudulent statement by a claimant or dependent constitutes grounds for the denial of all benefits for the claimant or dependents, or the cancellation or recovery of benefit payments made in reliance thereon.
Member Signature _____ Date Signed _____