IBEW LOCAL 400 WELFARE FUND
COORDINATION OF BENEFITS FORM

PRINT ALL INFORMATION

Participant Last Name _____ Participant First Name _____ M.I. _____ Social Security Number _____

Home Address: _____

City _____ State _____ Zip code _____ Phone # _____

Please check here, sign and date below if no family members have medical/dental coverage ☐

Complete the following section for each family member and indicate below those that have **other** coverage

	Last Name, First Name and Middle Initial	Sex	DOB	Social Security Number	Please indicate here if member/dependent has other medical/dental coverage	Type of coverage- family/single/ parent/child(ren)	Please list name of other insurance carrier /plan or Medicare	Please include **copies** of all other medical and or dental **cards**
Participant		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Spouse		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.

_____ _____

Participant Signature Date

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Participant Last Name	Participant First Name	M.I.	Social Security Number

PAGE 2 - ADDITIONAL CHILDREN

Complete the following section for each child and indicate below those that have **other** coverage

	Last Name, First Name and Middle Initial	Sex	DOB	Social Security Number	Please indicate here if dependent has other medical/dental coverage and effective date	Type of coverage- family/single/ parent/child(ren)	Please list name of other insurance carrier /plan or Medicare	Please include **copies** of all other medical and or dental **cards**
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #
Child to age 26		☐ F ☐ M			Medical ☐ Yes ☐ No **Effective Date**			Group # Policy #
					Dental ☐ Yes ☐ No **Effective Date**			Group # Policy #

I acknowledge by signing this form that all the information provided is true and correct to the best of my knowledge.

Participant Signature ______________________ Date ____________