

**IBEW LOCAL 456 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 <u>copies</u> of all other medical and or dental <u>cards</u>
Participant		<input type="checkbox"/> F			Medical <input type="checkbox"/> Yes <input type="checkbox"/> No			Group #
		<input type="checkbox"/> M			Effective Date _____			Policy #
		<input type="checkbox"/> F			Dental <input type="checkbox"/> Yes <input type="checkbox"/> No			Group #
		<input type="checkbox"/> M			Effective Date _____			Policy #
Spouse		<input type="checkbox"/> F			Medical <input type="checkbox"/> Yes <input type="checkbox"/> No			Group #
		<input type="checkbox"/> M			Effective Date _____			Policy #
		<input type="checkbox"/> F			Dental <input type="checkbox"/> Yes <input type="checkbox"/> No			Group #
		<input type="checkbox"/> M			Effective Date _____			Policy #
Child to age 26		<input type="checkbox"/> F			Medical <input type="checkbox"/> Yes <input type="checkbox"/> No			Group #
		<input type="checkbox"/> M			Effective Date _____			Policy #
		<input type="checkbox"/> F			Dental <input type="checkbox"/> Yes <input type="checkbox"/> No			Group #
		<input type="checkbox"/> M			Effective Date _____			Policy #
Child to age 26		<input type="checkbox"/> F			Medical <input type="checkbox"/> Yes <input type="checkbox"/> No			Group #
		<input type="checkbox"/> M			Effective Date _____			Policy #
		<input type="checkbox"/> F			Dental <input type="checkbox"/> Yes <input type="checkbox"/> No			Group #
		<input type="checkbox"/> M			Effective Date _____			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
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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 <u>copies</u> of all other medical and or dental <u>cards</u>
Child to age 26		<input type="checkbox"/> F			Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____			Group # _____ Policy # _____
		<input type="checkbox"/> M			Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____			Group # _____ Policy # _____
Child to age 26		<input type="checkbox"/> F			Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____			Group # _____ Policy # _____
		<input type="checkbox"/> M			Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____			Group # _____ Policy # _____
Child to age 26		<input type="checkbox"/> F			Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____			Group # _____ Policy # _____
		<input type="checkbox"/> M			Dental <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____			Group # _____ Policy # _____
Child to age 26		<input type="checkbox"/> F			Medical <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____			Group # _____ Policy # _____
		<input type="checkbox"/> M			Dental <input type="checkbox"/> Yes <input type="checkbox"/> 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