Food Employers Labor Relations Association
And United Food And Commercial Workers
VEBA Fund

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Coordination of Benefits Questionnaire

Please complete and return in postage paid, self-addressed envelope as soon as possible.

Dear Plan Participant,

Coordination of Benefits occurs when you are covered by this Plan and another group health plan. The purpose of the form is to update the Fund Office's records on group coverage available to you and your dependents. The Board of Trustees has directed that this questionnaire be sent every two years. Your cooperation is greatly appreciated! **Please return this form as soon as possible.**

1. Marital Status (circle one): Single Married Separated (Date of Separation: _____________) Divorced (Date of Divorce: ___________)
2. Are you married to another Fund participant or is your dependent child a Fund participant? Yes ☐ No ☐.

   If yes, please provide his/her Medical Card ID Number:____
3. Please list all family members (do not include yourself) who are enrolled as your dependents under this Plan:

Dependent's Name	Relationship	Birth Date	Dependent's Employer, if Any, Including Telephone Number

[OVER]

4. Do you and/or your dependents have other health insurance? If so, please provide the following information. If no other coverage is available, please indicate by writing **'N/A'**.

Who is Covered? (Provide Dependent's Name)	**Name of Insurance Plan**	**Group Number**	**Policy Number**	**Effective Date**	**What is Provided? Medical/Optical/Dental/ RX Drug**
You?					
Spouse?					
Child?					
Child?					
Child?					

5. If you provided other coverage information in question 4, please indicate the **source of this coverage**, such as your spouse's employer, another employer of yours, etc.____

6. Were you and/or your dependents offered other coverage that was declined? If so please indicate the source of this coverage and whether the declining person received **any other benefit** for declining?

____

____

I acknowledge that the above information is true and complete. I am aware that if circumstances change regarding other coverage which is offered to or becomes available to me or my dependents, I must notify the Fund office immediately.

____
Participant's Signature

____
Medical Card Id Number

____
Print Name

____
Telephone Number (in case of questions only)

____
Date

____
E-Mail Address (in case of questions only)