Associated Administrators, LLC
UFCW Local 1500 Welfare Fund
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Coordination of Benefits Questionnaire

Dear Plan Participant,

Coordination of Benefits occurs when you are covered by this Plan and another group health plan. The coordination of benefits rules are designed to avoid double payments being made, and at the same time, assure that you have received the maximum health coverage to which you are entitled by making sure each group health plan under which you are covered pays its appropriate share of your medical expenses. The purpose of the form is to update the Fund office's records on group coverage available to you and your dependents.

Please be sure to return this form at your earliest convenience. Do not include anything other than your COB form in this enclosed envelope! If you do, it may not reach the correct department in a timely manner.

1. Are you married to another Fund participant or is your dependent child a Fund participant? Y / N. If yes, please provide his/her Social Security Number:_____.

2. 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 #

3. 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?					

4. If you provided other coverage information in question 3, please indicate the **source of this coverage**, such as your spouse's employer, another employer of yours, etc._____

5. 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

_____ Print Name

_____ Date

_____ Participant's Social Security Number

_____ Telephone Number (in case of questions only)

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