Associated Administrators, LLC
UFCW Local 1500 Welfare Fund
P. O. Box 1095
Sparks, Maryland 21152-1095
Phone: (855) 266-1500
www.associated-admin.com

Dear Member:

Coordination of Benefits occurs when you are covered by this Plan and another group health plan. Please provide this office with the following information to ensure that we have updated records on group health coverage available to you and your dependents, including your spouse.

Your plan has a Coordination of Benefits provision. The spouse of a member will not be eligible for coverage under the UFCW Local 1500 Welfare Fund if the spouse fails to elect available health coverage in his/her employer plan regardless of the premium charged by the spouse's employer or the level of benefits provided by the spouse's employer.

If your spouse or dependents have their own policy with the UFCW Local 1500 Welfare Fund, and they are also covered under your Plan, please specify his/her name and social security number:

Name(s): _____ Social Security Number(s): _____

Please list all family members (not including yourself) that should be enrolled as dependents under this Plan:

Dependent's Name	Relationship	Date of Birth	Dependent's Employer, if any, including address and telephone number

Please complete the chart below to determine primary coverage. If no other coverage is *available*, please write, "N/A."

Who is covered? Please list names below.	**Name of insurance plan:**	**Group Number:**	**Policy Number:**	**Effective Date:**	**What type of coverage is provided?**
Member:					
Spouse:					
Child:					
Child:					
Child:					

If you provided other coverage information in the chart above, please indicate the source of this coverage along with the insurance carrier's address. For example: spouse's employer, another employer of yours, etc.

Source of coverage: _____ **Address:** _____

_____

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

_____ _____

Member's Name (Please Print) **Member's Social Security Number**

_____ _____

Member's Signature **Telephone Number (in case of questions only)**

_____ _____

Date **Email Address (in case of questions only)**