Carpenters' Local No. 491
Health and Welfare Plan
911 Ridgebrook Road
Sparks, Maryland 21152-9451
Toll Free Telephone (888) 494-4443
www.associated-admin.com

Coordination of Benefits Questionnaire

Dear Plan Participant,

It is our company policy to request coordination of benefits information on all of our members' dependents. This policy requires you to give us the information needed below which will make us aware of your spouse/dependents other medical coverage and to assure that all claims are paid correctly. **If your spouse/dependents do not have any other medical coverage, you must complete the "Affidavit For Other Insurance" (see page 3 of this form) and have it notarized prior to returning the form to the Fund office.** If your spouse/dependents have no other form of coverage, you do not need to complete this form.

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? Y / N. If yes, please provide his/her Social Security 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 #

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 3, 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

_____ Participant's Social Security Number

_____ Print Name

_____ Telephone Number (in case of questions only)

_____ Date

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

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AFFIDAVIT FOR OTHER INSURANCE

I, _____, (name of participant), Social Security Number_____, affirm that the following facts are true and complete.

I certify, as of this date, no person in my family who is covered for benefits as my dependent under the **Carpenters' Local No. 491 Health and Welfare Fund** has any additional health insurance coverage through employment or private means.

I affirm that under the penalties of perjury that the statements set forth in this Affidavit are true. I understand that any false statement or any misrepresentation in this Affidavit will subject me to civil liability for benefits and costs, including attorneys' fees, paid by the Fund on my behalf. In addition, it could result in loss of benefits, and the act itself constitutes a criminal offense.

_____ _____

Date Participant's Signature

Affidavit MUST be notarized by a Notary Public.

State of _____
City/County of_____

Before me on the _____ day of _____, 20_____ personally appeared,_____ (name of participant), who is known to me (or who has satisfactorily proved his/her identity) who stated to me that each and every statement in this Affidavit is true and correct to the best of his/her knowledge, and he/she knowingly and intentionally executed the Affidavit for the purpose of obtaining Health and Welfare Benefits from the **Carpenters' Local 491 Health and Welfare Fund.**

Notary Public: _____
My Commission Expires:_____