Central Pennsylvania Teamsters Health and Welfare Fund

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I M P O R T A N T
PLEASE COMPLETE THIS FORM AND RETURN TO THE FUND OFFICE
TO THE ATTENTION OF CHRIS R.
ANNUAL COORDINATION OF BENEFITS (COB) FORM

Participant's Name:_____
Current Mailing Address:_____
City_____ State _____ Zip Code_____
Participant's I.D.#_____ Email Address: _____
Home Telephone No. ( )_____ Mobile Phone No. ( )_____
Spouse's Name:_____Spouse's Birthdate_____

PLEASE COMPLETE THIS SECTION ONLY IF YOU OR YOUR DEPENDENTS ARE ENROLLED IN MEDICARE, DISABILITY MEDICARE, OR ESRD PROGRAM.

Member YES NO	Spouse YES NO	Dependent Child Name _____
Medicare Eligibility due to:	Medicare Eligibility due to:	Medicare Eligibility due to:
___Age ___ Disability	___Age ____Disability	___ Disability
___ Kidney transplant	___Kidney transplant	___ Kidney transplant
___Dialysis	___Dialysis	___ Dialysis
Part A effective date:_____	Part A effective date:_____	Part A effective date:_____
Part B effective date:_____	Part B effective date:_____	Part B effective date:_____
MBI No._____	MBI No._____	MBI No._____

(MBI Number is 11 characters consisting of alpha and numeric on ID Card)

PLEASE COMPLETE ALL QUESTIONS REGARDING SPOUSE INFORMATION
Attention: Please read Notice of Waiver Rules on the next page
Is Participant's spouse employed? YES NO If YES, Effective Date_____
If yes, please check either full time_____ or part time (less than 35 hours)_____
Name of spouse's employer_____
Address of spouse's employer_____
Telephone number of spouse's employer (___)_____
Does your spouse have medical insurance through their employment? **YES NO**
Type of coverage: Single Family Other:_____I.D.#_____
Name of insurance carrier_____
Effective date of coverage_____
Telephone number of insurance carrier (___)_____
Do you participate in an HSA? **YES NO**
Do you participate in an HRA? **YES NO**

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DO ANY OF YOUR DEPENDENTS OVER AGE 18 HAVE INSURANCE? **YES** **NO**
CHILD NAME_____COV IS UNDER CHILD___ CHILD'S SPOUSE____
STEP PARENT ___ PARENT____ INS. CARRIER____ GOV. PROGRAM ___ EFF. DATE_____

PLEASE COMPLETE FOR DEPENDENT(S) IF THE NATURAL PARENT IS NOT ON POLICY

Is there a natural mother or father for your dependent child/children other than you or the current spouse listed on the previous page? **YES** **NO**

Natural mother/father's name and address_____

_____

Natural mother/father's birthdate:_____

Name(s) of dependent children:_____

_____

Natural mother/father's Employer's name and address:_____

_____

Employer's telephone number: (___)_____

Is there a domestic relations order or settlement agreement regarding responsibility to provide insurance coverage which could impact the Coordination of Benefits on behalf of your natural children? **YES** **NO**
If yes, a copy of such order/agreement is required and must be provided to the Fund Office.

Are any of the above-named dependent children covered by any other Medical coverage?
YES **NO** If yes, please complete the following:

Name of individual providing coverage:_____ID#_____

Individual's relationship to child/children:_____

Name(s) of child/children covered under this policy:_____

_____

Name of Medical Insurance Carrier_____Effective Date_____

Medical Insurance Carrier's Telephone Number_____Policy I.D.#_____

Is there an HRA account? **YES** **NO** Is there an HSA account? **YES** **NO**

IMPORTANT: Child/Children's place of residence (list name of child and complete address):_____

_____

IF COVERAGE IS UNDER A DEPENDENT OR FAMILY OPT OUT, DISREGARD THE BELOW

IMPORTANT NOTICE REGARDING WAIVER RULES

If your spouse works and Medical coverage is available through his/her employment, an election must be made to participate under that coverage even though your spouse may have to pay part of the cost. If your spouse is required to pay 100% of the premium, we must have a letter from the employer stating that fact, and then your spouse does not have to enroll. If your spouse elects not to participate, it is a violation of your Plan's waiver rules. This will result in your spouse's ineligibility as a dependent for benefit coverage purposes with our Fund. If you have any questions regarding this provision please contact the Fund Office at (610) 320-5500 or toll free nationwide at (800) 331-0420.

Participant's Name_____

Participant's I.D.#_____

I authorize my employer and any health insurance carrier providing insurance through my employer to release to the Central Pennsylvania Teamsters Health and Welfare Fund ("Fund") any and all information regarding my eligibility for or enrollment in any health plan offered by my employer. I understand that the Fund requires this information in order to administer the coordination of benefits provisions of the Fund's plan of benefits, as permitted under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and regulations thereunder. I understand that both my employer's health plan and the Fund are "covered entities" under HIPAA and must, therefore, protect my health information as required by that statute and regulations. The applicable regulations are set forth at 45 CFR Parts 160 and 164. I understand that this authorization is voluntary and that I can revoke it at any time by informing my employer and the employer's health plan in writing that I am revoking this authorization. This authorization will automatically expire ninety (90) days from the date of this authorization.

Spouse's Name:_____

Spouse's Signature: _____

Date:_____