

COORDINATION OF BENEFITS INFORMATION

SECTION 1 YOUR MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND INFORMATION

Participant Name (as found on your ID card)	Participant Contract ID
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Have you, your spouse or your dependents been covered by other group health insurance or Medicare in the past year?

NO – Please skip the rest of the questions, sign the bottom of this form, and return to MCTWF. YES – Please complete the entire form, sign the bottom of this form, and return to MCTWF.

SECTION 2 OTHER GROUP HEALTH INSURANCE INFORMATION

Please provide the following information about the cardholder of the other group health insurance as it appears on his or her ID card. If more than one other group health insurance exists, please attach additional pages as needed with the same required information.

Cardholder Name	Relationship to you	Date of Birth
Other Group Health Insurance Name and Phone Number		Policy Number
Type of Medical Plan: <input type="checkbox"/> Medicare / Medigap <input type="checkbox"/> Group Health <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual Policy <input type="checkbox"/> COBRA Policy <input type="checkbox"/> Retiree Policy	Effective Date of Coverage	Termination Date (attach carrier letter)
Type of coverage: (check all that apply) <input type="checkbox"/> Medical <input type="checkbox"/> Vision <input type="checkbox"/> Dental <input type="checkbox"/> Prescription Drugs	Employer	

Who is covered by this other group health insurance? Include yourself if applicable.

<u>Name (first and last)</u>	<u>Relationship to You</u>	<u>Date of Birth</u>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

SECTION 3 SPECIAL SITUATIONS

Fill out this section only if your children have other group health insurance in addition to the above in Section 2 because of divorce, separation or court order.

Is there a court order that determines responsibility for health care coverage or custody?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	(attach a copy of the sections that apply to health care responsibility and/or custody arrangements)
Name of person responsible for child's health care coverage	Employer	Date of Birth	
Other Group Health Insurance Name and Phone Number		Policy Number	
Type of Medical Plan: <input type="checkbox"/> Medicare / Medigap <input type="checkbox"/> Group Health <input type="checkbox"/> Medicaid <input type="checkbox"/> Individual Policy	Effective Date of Coverage	Termination Date (attach carrier letter)	

SECTION 4 MEDICARE COVERAGE

Fill out this section only if you, your spouse or your dependents are eligible for Medicare insurance coverage.

Name of Person Eligible for Medicare	Date of Birth
Is this Medicare Coverage due to End Stage Renal Disease (ESRD)? <input type="checkbox"/> Yes <input type="checkbox"/> No	
1st Date of Dialysis:	If Medicare is due to other disability, please include a brief description:

I understand that if I do not provide complete and accurate information or do not promptly notify MCTWF of changes in information, my benefits may be suspended until I have provided complete and accurate information to MCTWF, and MCTWF will seek recovery from me for benefits paid in error.

Participant Signature: _____ Date: _____

Return completed form to: Michigan Conference of Teamsters Welfare Fund
 2700 Trumbull Avenue
 Detroit, Michigan 48216
 (800) 572-7687
 Fax Number: (313) 748-4330
 www.mctwf.org