PLUMBERS' LOCAL UNION NO. 130 WELFARE FUND

Coordination of Benefits Form - 2017

1340 W. Washington
Blvd., Ste. 303
Chicago, IL 60607
Phone 312-226-5000
Fax 312-226-7285

Your insurance with Plumbers' Local 130 Welfare Fund contains a Coordination of Benefits provision. Processing of claims submitted under your contract depends upon your response.

Section #1 - Information about You

Member's Name: _____ Soc. Sec. No.: _____
(Last) (First) (M.I.)

Home Address: _____City: _____State: _____Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Section #2 - Information about Your Spouse

Name (first, initial, last):	Date of Birth:	Social Security Number:

Is your spouse employed? ❑ No ❑ Yes (If *yes*, complete employer information below.)

Employer:	Employer's Telephone Number:		
Employer's Street Address:	City:	State:	Zip:

Section #3 - Other Insurance

Besides being covered by Plumbers' Local 130 Welfare Fund, are you, your spouse or any other family member currently covered by any other plan (including group insurance, prescription drug, dental, vision, student or sports policies or Medicare)?

❑ No (If "No" complete Section 5 below) ❑ Yes (If "YES" complete Sections 4 and 5 below)

Section #4 - Other Insurance Information

Please indicate below the type of other insurance coverage you have by marking "YES" or "NO." If you answer "YES" please complete the area to the right of the box.

Type of Coverage:	**Insurance Company or Carrier Name and Phone Number:**	**Policy Holder's Name and I.D. Number:**	**Effective Date and Termination Dates:**	**Who is Covered?**
Medical ❑ No ❑ Yes	Carrier: Phone:	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	❑You ❑Spouse ❑Children
Pres. Drug ❑ No ❑ Yes	Carrier: Phone:	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	❑You ❑Spouse ❑Children
Dental ❑ No ❑ Yes	Carrier: Phone:	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	❑You ❑Spouse ❑Children
Vision ❑ No ❑ Yes	Carrier: Phone:	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	❑You ❑Spouse ❑Children
Medicare ❑ No ❑ Yes	 (Not required for Medicare.) 	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	❑You ❑Spouse ❑Children
Other ❑ No ❑ Yes	Carrier: Phone:	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	❑You ❑Spouse ❑Children

Section #5. Sign and Date – Return Form to the Fund Office

X_____ _____
Member's Signature Date

Please return the form in the enclosed envelope or return to the address at the top of this form. It is your responsibility to inform the Fund Office of any changes which occur during the calendar year. Thank you.

Cob Inquiry Form 2017