FUND OFFICE OF LOCAL 580 ARCHITECTURAL & ORNAMENTAL IRON WORKERS

Administrative Office of:

LOCAL 580 INSURANCE FUND

Second Floor • 501 WEST 42nd STREET • NEW YORK, NY 10036 • (212) 695-5206

FAX (212) 947-5719

Coordination of Benefits Form

This form is to be completed **ONLY** by the Human Resources Department. Coordination of Benefits (COB) is a way to coordinate benefit payments when you or your dependents are covered by more than one health plan. By keeping Local 580 Insurance Fund ("the Plan") informed you enable the timely and accurate processing of claims. All questions must be answered completely. The Human Resources Department representative should sign and date the reverse side of this form. **PLEASE TYPE OR PRINT LEGIBLY.**

SUBSCRIBER INFORMATION (Please Print Clearly or Type)

Policyholder Name:_____ Date of Birth: _____

EMPLOYMENT INFORMATION (Please check the appropriate boxes)

Actively working?: □ Yes □No Date of Retirement: _____/_____/_____

Retired?: □Yes □ No

Employer Name: _____

Employer Address: _____ City:_____ State: _____ Zip:_____

COVERAGE INFORMATION: List each insurance benefit separately

Check all types of coverage that insurance company provides:

Type of plan(s): [ ]Hospital [ ]Medical [ ]Major Medical [ ]Dental [ ]Mental Health [ ]Substance Abuse [ ]Optical [ ]Drug

Type of coverage: [ ] Single [ ] Family [ ] Husband & wife [ ] Parent & Child(ren) [ ] Spouse & Child(ren)

Insurance Company: _____ **Effective Date:** _____

Identification number: _____ **Termination date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Name of covered dependents:_____

Check all types of coverage that insurance company provides:

Type of plan(s): [ ]Hospital [ ]Medical [ ]Major Medical [ ]Dental [ ]Mental Health [ ]Substance Abuse [ ]Optical [ ]Drug

Type of coverage: [ ] Single [ ] Family [ ] Husband & wife [ ] Parent & Child(ren) [ ] Spouse & Child(ren)

Insurance Company: _____ **Effective Date:** _____

Identification number: _____ **Termination date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Name of covered dependents:_____

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Type of coverage: [ ] Single [ ] Family [ ] Husband & wife [ ] Parent & Child(ren) [ ] Spouse & Child(ren)

Insurance Company: _____ **Effective Date:** _____

Identification number: _____ **Termination date:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Name of covered dependents: _____

Human Resources Representative (REQUIRED)*

I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed the stated value of the claim for each such violation.

Signature: _____

Name: _____

Title: _____

Contact Number: _____

Date Completed: _____

***This form will not be accepted without signature, phone number, name and signature of person completing this form.**

FOR OFFICE USE ONLY

Member: _____

Id#: _____ System Changed: _____

Initials: _____

Notes: _____