

Pipe Fitters Local No. 533 Health and Welfare Plan

8600 Hillcrest Road, Suite A / Kansas City, MO 64138 (ph) 816-361-0206

Coordination of Benefits

SECTION 1

Participant Name: _____ Participant ID _____

Are you, your spouse or any of your dependents covered by another health plan other than Medicare?

<input type="checkbox"/> -NO – Please skip the rest of the questions Sign the bottom of this form and return.	<input type="checkbox"/> YES – Please complete the entire form, Sign the bottom of the form and return.
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SECTION 2 OTHER HEALTH COVERAGE INFORMATION

Please provide the following information about the policyholder of the other health coverage.

Name of policyholder		Relationship to you		Birth Date		
Insurance company name		Insurance company city		State	Phone number	
Enrollee ID/policy number		Group number		Effective date		Cancellation date (if applicable)
Type of coverage <input type="checkbox"/> Single <input type="checkbox"/> Family		Type of Plan (Check all that apply) <input type="checkbox"/> Medical <input type="checkbox"/> Prescription drug <input type="checkbox"/> Dental <input type="checkbox"/> Medicare Advantage				

Who is covered by this other plan? Include yourself if applicable.

Name (first and last)	Relationship to you
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Participant signature: _____ **Date:** _____