



## 2022 Coordination of Benefits Claim Number:

We are in receipt of the above referenced claim. The Plan in which you and your dependent(s) are covered contains a Coordination of Benefits provision that makes it necessary for us to periodically request new and/or updated information as it relates to the possibility of other insurance coverage. Please answer the following questions and return this form to us as quickly as possible to prevent further delay in the processing of your claim and ensure proper benefit payment.

Participant Information		
<b>Participant's Full Name</b> (Last, First, M.I.):		<b>Date of Birth</b> (mm/dd/yyyy):
<b>BCBS ID#:</b>	<b>OR Social Security #:</b>	
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Legally Separated	
<b>Street Address</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Home Phone #:</b>	<b>Cell Phone #:</b>	
<b>Email Address:</b>		

If your spouse is to be covered on the Plan, you must provide their social security number for Medicare Reporting purposes.

Spouse Information	
<b>Spouse Name</b> (Last, First, M.I.):	<b>Date of Birth</b> (mm/dd/yyyy):
<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Social Security #:</b>
<b>Does your spouse have other insurance/coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If yes, please complete ALL of the following:</b>	
<b>Spouse's Employer:</b>	
<b>Spouse's Insurance Co.:</b>	<b>Policy#:</b>
<b>Spouse's Effective Date of Other Insurance Coverage:</b>	

Dependent Information - Please list all other enrolled dependents below				
Relationship	Name (Last, First, M.I.)	Date of Birth (mm/dd/yyyy)	Gender	Social Security #
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Child			<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Do any of your dependent children have other insurance/coverage?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No				

<b>If yes, please complete ALL of the following:</b>	
<b>Dependent's Name:</b>	
<b>Dependent's Employer:</b>	
<b>Dependent's Insurance Co.:</b>	<b>Policy #:</b>
<b>Dependent's Effective Date of Other Insurance Coverage:</b>	

Medicare Information	
<b>Are you and/or your dependents Medicare eligible?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>If yes, please list who is eligible and the reason:</b>	
Name	Reason
	<input type="checkbox"/> Age 65+ <input type="checkbox"/> Disabled under age 65 <input type="checkbox"/> End Stage Renal Disease or Disabled ESRD
	<input type="checkbox"/> Age 65+ <input type="checkbox"/> Disabled under age 65 <input type="checkbox"/> End Stage Renal Disease or Disabled ESRD
	<input type="checkbox"/> Age 65+ <input type="checkbox"/> Disabled under age 65 <input type="checkbox"/> End Stage Renal Disease or Disabled ESRD
Effective Date For:	
<b>Medicare Part A:</b>	<b>Medicare Part B:</b>
	<b>Medicare Part D:</b>

Financial Responsibility Information
<b>Do you have a dependent child covered under this plan and someone else has financial responsibility?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If yes, indicate who and under what circumstances:</b>
<b>If yes, please send us a copy of the page(s) from the legal document (court decree, divorce decree, etc.) that validates this requirement.</b>

## Certification

I certify that these statements and answers are true to the best of my knowledge and belief. Please sign and return.

I understand and accept that my typed name below functions as my legal signature on this document.

**Participant's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print Name:** \_\_\_\_\_

**Thank you for helping us serve you better. Please return this completed form by mail or fax to:**

Professional Benefit Administrators, Inc.

900 Jorie Blvd, Suite 250

Oak Brook, IL 60523

Fax: (630) 286-4678

Email: 701claim@mech701-benefits.org

\*\*If you elect to submit any documents or other information via email to the Welfare Fund, we encourage you to use encryption or another secure method.\*\*