



Employee:  
 Address:  
 Date:  
 Dependent Name(s):  
 ID Number:

The Group Health Insurance Plan in which you and your dependent(s) are covered contains a Coordination of Benefits ("COB") provision that **requires other insurance information be provided once a year. Failure to do so will result in claims being denied for payment until received.**

Please complete the below questionnaire and provide the information in one of the following methods.

- Mail to: Professional Benefit Administrators, Inc  
 PO Box 4687  
 Oak Brook, IL 60522-4687
- Fax to 630-286-4678
- Email to **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.)

Section 1: Spouse Info			
Is your spouse employed? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Does not apply			
If yes, is your spouse eligible for coverage through his/her employer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, did your spouse elect insurance coverage through his/her employer? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please complete the following:			
Spouse ID#:		Spouse Name:	
Spouse Date of Birth:		Employer Name/Phone:	
Employer Address:			
Insurance Company Name:			
Insurance Company Phone#:			Plan #:
Is this an HMO policy? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Coverage (Mark all that apply)			
<input type="checkbox"/> Medical	<input type="checkbox"/> Single	<input type="checkbox"/> Family	Effective Date _____
<input type="checkbox"/> Dental	<input type="checkbox"/> Single	<input type="checkbox"/> Family	Effective Date _____
<input type="checkbox"/> Vision	<input type="checkbox"/> Single	<input type="checkbox"/> Family	Effective Date _____
<input type="checkbox"/> Rx	<input type="checkbox"/> Single	<input type="checkbox"/> Family	Effective Date _____

If your spouse no longer has coverage, please provide the termination date. (Please forward a copy of your creditable coverage letter/termination letter verifying date the coverage terminated.)

Please list all family members covered under the other insurance coverage. If more than one insurance carrier exists, list the name, address, phone number and group/plan number of the other insurance carrier(s):

## Section 2: Medicare

Are you and/or your dependents Medicare eligible?  Yes  No

If yes, please list who is eligible and the reason (Age 65 or older, Disabled under age 65, End Stage Renal Disease or Disabled ESRD):

Effective Date For: Medicare Part A \_\_\_\_\_ Medicare Part B \_\_\_\_\_ Medicare Part D \_\_\_\_\_

## Section 3: Financial Responsibility

Do you have a dependent child under this plan and someone else has financial responsibility?

Yes  No  Does not apply

If yes, please send us a copy of the page(s) from the legal document (court decree, divorce decree, etc.) that validates this requirement. If you have already submitted these legal documents, you may disregard this request.

If no, please check the following statements as they apply to your situation:

- The responsible party does not currently provide insurance coverage for the dependent(s).
- The responsible party cannot be located.
- There is no court order or divorce decree on file.
- Father/Mother deceased.

If there is no court order or divorce decree:

Please provide other biological parent's name and date of birth.

Does the other biological parent have other insurance through an employer?  Yes  No

Are the biological parents living together?  Yes  No

If the biological parents are not living together, who has primary physical custody of the child?

**Section 4: Adult Dependent Child**

Do you have a dependent child over the age of 19 (Adult Dependent Child) who is enrolled for other coverage through their employer sponsored group health plan or their spouse's employer sponsored group health plan?  Yes  No

If yes, please indicate which child:

Insurance Company Name:

Insurance Company Phone #:

Plan #:

If yes, please indicate which child:

Insurance Company Name:

Insurance Company Phone #:

Plan #:

If yes, please indicate which child:

Insurance Company Name:

Insurance Company Phone #:

Plan #:

**Certification**

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

Participant Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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

Thank you for helping us serve you better.

Sincerely,  
Claims Department  
Professional Benefit Administrators, Inc.