Pipe Fitters' Welfare Fund, Local 597

45 North Ogden Avenue Chicago, Illinois 60607 phone (312) 633-0597 fax (312) 829-7787 www.pf597.org

Coordination of Benefits Form

Your insurance with Pipe Fitters' Local 597 Welfare Fund contains a Coordination of Benefits provision. Processing of your dependent's claims submitted under your contract depends upon your response.

Member's Name _____ (First) _____ (Middle) _____ (Last)

_____ (Social Security Number) _____ (U.A. Card Number) _____ (Date of Birth)

Address _____ (Street) _____ (City) _____ (State) _____ (Phone Number)

1. Information about your spouse:

If you are married, please complete this section. If not, please proceed to Section 2 below.

Name _____ (First) _____ (Middle) _____ (Last)

_____ (Social Security Number) _____ (Date of Birth)

Is your spouse employed? □ No □ Yes (if yes, complete employer information below)

Employer: _____ (Name) _____ (Phone Number)

Address _____ (Street) _____ (City) _____ (State)

Is your spouse retired with insurance? □ No □ Yes

2. Other Insurance?

Besides being covered by Pipe Fitters' Local 597 Welfare Fund, are you, your spouse, your children or former family members that are currently covered by the 597 Fund also covered by any other plan (including group insurance, prescription drug, dental, vision, student or sports policies, or Medicare)?

□ No (If no, proceed to section 4 below) □ Yes (If yes, complete section 3 below)

3. Tell us about your other insurance:

Please indicate below the type of other insurance coverage you have by marking yes or no. If you mark yes, please complete the areas to the right of the box. Send a copy of the front and back of your I.D. card.

Type of Coverage	Insurance Company Name and Phone Number	Policy Holders Name and I.D. Number	Effective Date	Who is Covered
Medical □ No □ Yes				□ 597 Member □ Spouse □ Children
Prescription Drug □ No □ Yes				□ 597 Member □ Spouse □ Children
Dental □ No □ Yes				□ 597 Member □ Spouse □ Children
Vision □ No □ Yes				□ 597 Member □ Spouse □ Children
Medicare □ No □ Yes *** If yes, please provide a copy of your Medicare Card***				□ 597 Member □ Spouse □ Children
Other □ No □ Yes				□ 597 Member □ Spouse □ Children

4. Please read the following information carefully.

If there have been any changes to your other insurance policy for you or your dependents you must notify the Plan Administrator in writing within 60 days. If you or your dependents have been terminated from another insurance policy you must supply the Fund Office with the termination letter. It is your responsibility to inform the Fund Office of any changes which occur.

We jointly certify that the above information is true and correct. We also authorize any Union, Trust Fund, Employer, or Insurance Carrier to furnish Pipe Fitter's Welfare Fund with information regarding benefits to which we may be entitled.

5. Please sign, date and return this form in the enclosed envelope or return to the address at the top of this form.

_____ Member Signature _____ Date

_____ Spouse Signature _____ Date