

Pipe Fitters' Welfare Fund, Local 597

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

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 Initial	Last
Address	Social Security #	Local 597 Union #	
	Street	City	State Zip Code
	Phone #	Date of Birth	

1. Information about your spouse:

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

Name

	First	Middle Initial	Last
	Social Security #	Date of Birth	
	Is your spouse employed? <input type="checkbox"/> No <input type="checkbox"/> Yes (if yes, complete employer information below)		

Employer

	Name	Phone #
Address	Street	City State

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.

Type of Coverage	Insurance Company or Carrier Name Address and Phone Number	Policy Holders Name and Group Number	Effective Date	Who is Covered
Medical <input type="checkbox"/> No <input type="checkbox"/> Yes				<input type="checkbox"/> 597 Member <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Prescription Drug <input type="checkbox"/> No <input type="checkbox"/> Yes				<input type="checkbox"/> 597 Member <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Dental <input type="checkbox"/> No <input type="checkbox"/> Yes				<input type="checkbox"/> 597 Member <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Vision <input type="checkbox"/> No <input type="checkbox"/> Yes				<input type="checkbox"/> 597 Member <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Medicare <input type="checkbox"/> No <input type="checkbox"/> Yes *** if yes, please provide a copy of your Medicare Card***				<input type="checkbox"/> 597 Member <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Other <input type="checkbox"/> No <input type="checkbox"/> Yes				<input type="checkbox"/> 597 Member <input type="checkbox"/> Spouse <input type="checkbox"/> 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 responsible 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
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