PIPEFITTERS WELFARE FUND, LOCAL 597
COORDINATION OF BENEFITS FORM

Phone (312) 633-0597 - Fax (312) 829-7787

www.pf597.org

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

Email Address _____ U.A. Card Number _____ Date of Birth _____

Home Address _____ Phone Number _____

1. Information about your spouse or adult dependent child:

If you are married or have an adult dependent child, 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 or dependent 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				☐ 597 Member ☐ Spouse ☐ Children
****** If yes, please provide a copy of your Medicare Card if not previously sent******				
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 or Dependent Signature _____ Date _____