

Mahoning & Trumbull County Building Trades Insurance Fund

33 FITCH BLVD • AUSTINTOWN, OH 44515

Austintown (330) 270-0453

Youngstown Phone (330) 530-2841

COORDINATION OF BENEFITS QUESTIONNAIRE

PLEASE COMPLETE AND RETURN TO THE FUND OFFICE

Member's Name _____ Social Security No. _____

ARE OTHER FAMILY MEMBERS EMPLOYED, OR ARE YOU EMPLOYED ELSEWHERE? ___ Yes ___ No

If Yes:

Employee Name _____ Social Security No. _____

Employer Name _____

Employer Address _____

Employer Telephone No. _____ Effective Date of Coverage _____

ARE ANY FAMILY MEMBERS' EXPENSES COVERED BY ANOTHER GROUP MEDICAL PLAN? ___ Yes ___ No

If Yes: Name of Other Insurance: _____ PHONE # _____

Address of Other Insurance Company or Administrator: _____

Employer or Group Name: _____

Group No. _____

Name of Person Carrying Insurance: _____

Social Security No. _____ Birthdate _____

Relationship to Member _____

HAS ANY FAMILY MEMBER DECLINED COVERAGE AVAILABLE UNDER ANOTHER GROUP HEALTH PLAN?

_____ Yes _____ No

If Yes: Are employees required to contribute toward the cost of this coverage? ___ Yes ___ No

Amount of contribution required \$ _____

As a result of declining this coverage, were other benefits made available to the employee? ___ Yes ___ No

Other benefits received _____

INTENTIONALLY WITHHOLDING OR FALSIFYING INFORMATION REQUESTED ON THIS QUESTIONNAIRE
MAY RESULT IN LOSS OF COVERAGE FOR YOU AND YOUR DEPENDENTS.

Date

Member's Signature

(If employment circumstances of other family members should change, you should notify the Fund Office and supply the information requested above.)