I.B.E.W. Local 688 Health & Welfare Plan

33 Fitch Boulevard
Austintown, Ohio 44515

PHONE: 800-435-2388
FAX: 330-270-0912

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: Is coverage for ________ family ___________ single?

Does coverage include: Vision ____ Dental ____ Prescription ____

If Yes: Name of Other Insurance: ______________________

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 contribution 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.)