Roofers Local 195 Health & Accident Fund

*(Complete separate forms for **each dependent** with **OTHER** coverage)*

COORDINATION OF BENEFITS QUESTIONNAIRE

EMPLOYEE INFORMATION:

First:	Middle:	Last:	Suffix	SS#:

SECTION 1: SPOUSE'S MEDICAL INFORMATION *SPOUSE'S FULL NAME:*

Is Your Spouse Medicare Eligible? *(Check One)*	Yes	No	If yes, Medicare Effective Date is:	*(If no, Skip to Section 2)*

Part A - ID #:	Part B - ID #:	Part D - ID#:

If Under age 65, What is the Reason for Medicare Eligibility?	

SECTION 2: SPOUSE'S EMPLOYER INFORMATION

Is Your Spouse Employed? *(Check One)*		Yes		Full Time		Part Time		No *(If No, Skip to Section 3)*

If yes, Name, Address & Phone Number of Spouse's Employer:		
Employer Name:	Employer Address	Employer Phone # ( )

SECTION 3. OTHER MEDICAL INSURANCE COVERAGE INFORMATION (All Family Members)

Do ***You or Your Dependents*** have **OTHER** Medical Coverage?		Yes		No *(if No, Skip to Section 4)*

Name of Dependent with **OTHER** Coverage?			***Policy Holder*** Date of Birth:
Name of ***Policy Holder***:	What Type of Coverage:	Family	Single
	Relationship to Policy Holder:		Group Number:

OTHER Insurance Covers: *(Check & Complete Applicable)*		Medical - ID#:		Dental – ID#:
		Prescription - ID#:		Vision – ID#:

Name, Address & Phone Number of **OTHER** Coverage(s)		
Carrier Name:	Carrier Address *(City, State, Zip)*	Carrier Phone #: ( )

Effective Date of Coverage:	Termination Date *(if applicable)*:

OTHER Coverage is: *(Check one)*		Employer Sponsored Plan		Medicaid Plan		Other

Is Dependent Medicare Eligible? *(Check One)*		Yes		No	Effective Date:

Part A – ID#:	Part B – ID#:	Part D - ID#:

If Under age 65, What is the Reason for Medicare Eligibility?

SECTION 4. SIGNATURE AND CONFIRMATION

I certify that the above information is true and understand that I may be held responsible for any overpayment made, on behalf of my dependent, due to misrepresented information.

( )

Employee Signature **Date** **Phone Number**

Under Federal Law, it is a crime to knowingly and willfully make a false statement in connection with the delivery, or payment, for health care benefits, or services (18 USC Sec. 1035). It is also a federal crime to attempt to defraud a health program, or knowingly and willfully steal, or otherwise convert money from, a health care fund (18 USC Sec. 669) (18 USC Sec 1347). These crimes are punishable by a fine, or imprisonment, or both.

Please submit copies of all Insurance Cards, Medicaid, and Medicare Cards, along with this completed form to:

Roofers Local #195 Fund Office, 7706 Maltlage Drive, Liverpool, New York 13090.