

WESTCHESTER PUTNAM COUNTIES HEAVY & HIGHWAY LABORERS
 BENEFITS FUND
 PENSION – WELFARE – ANNUITY – LEGAL – TRAINING
 LOCAL 60
 140 BROADWAY
 HAWTHORNE, NY 10532
 Tel: (914) 769-2440
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Union Trustees
 Anthony Ascencao
 Michael Moreira
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2017 COORDINATION OF BENEFITS FORM

Plan Participant, the Westchester Putnam Counties Heavy & Highway Laborers Local 60 Health & Welfare Plan has a Coordination of Benefits (COB) rule in order to determine whether your dependent(s) has other insurance coverage. If you are married or have dependent children, it is your responsibility to return this form to the fund office. If you are married or have an ex-spouse and dependent children, you are required to return this form before any claims will be paid on your dependents behalf. **If the fund office receives a claim(s) for your dependent(s) before you return this completed form, the claim(s) will be denied until this information is completed and returned.**

Please answer the questions below:

- Is your spouse or ex-spouse employed? Yes No
- Is your spouse or ex-spouse covered by any other insurance plan? Yes No
- Do you want to continue coverage for your dependents 19-26 years old (if applicable)? Yes No

If you indicated "YES" to any of the questions above, you must complete the following:

Spouse's Name _____ SS# _____ DATE OF BIRTH: _____

Dependent's Name _____ SS# _____ DATE OF BIRTH: _____

Dependent's Name _____ SS# _____ DATE OF BIRTH: _____

Spouse's Insurance information (other than Local 60 Health & Welfare Plan):

Hospital: Yes No Effective Date: _____ Policy#: _____

Medical: Yes No Effective Date: _____ Policy#: _____

Dental: Yes No Effective Date: _____ Policy#: _____

Prescription: Yes No Effective Date: _____ Policy#: _____

Optical: Yes No Effective Date: _____ Policy#: _____

Indicate Individual or Family coverage: _____

Insurance Carrier's name, address & phone number: _____

NOTE: A COORDINATION OF BENEFITS FORM MUST BE COMPLETED EACH CALENDAR YEAR.

PLEASE READ AND SIGN: I understand that if I knowingly defraud, conceal or provide false information for the purpose of misleading the Fund, my eligibility for Fund coverage will be terminated and I will be liable for any claims that were paid based on the false or misleading information. Your signature indicates that the information on this form is correct.

Signature of Member _____

Date _____

Member's Alternate I. D. Number: M2453000 OR: SS#: _____