IBEW Local 234 Health & Welfare Plan

Date: _____ Address: _____
Name: _____ City, State: _____
Subscriber ID#:_____

IF YOU DO NOT RESPOND TO THIS FORM COMPLETELY, PROCESSING OF CLAIMS FOR YOU AND YOUR DEPENDENTS WILL BE DELAYED. COPIES OF ALL INSURANCE CARDS MUST BE PROVIDED TO THE TRUST FUND TO PREVENT FURTHER DELAYS IN CLAIMS PROCESSING.

Your plan has a "Coordination of Benefits" provision which requires that we have information on file regarding other coverage available to you and your dependents. Please complete this form to the best of your ability and return to our office. If no other member of your family has other coverage, please check this box ☐, sign at the bottom and return the form to the above address.

Do you have other coverage? Please provide a copy of Insurance Card [s] [front and back]

Medical	☐ Yes	☐ No
Dental	☐ Yes	☐ No
Vision	☐ Yes	☐ No

If yes, please indicate other insurance company name, address, telephone#, effective date, policy# and Subscriber name: _____

Medical: _____ Effective Date: _____

Policy/Group#: _____ **Phone Number**: _____ HMO or PPO?: _____

Dental: _____ Effective Date: _____

Policy/Group# _____ **Phone Number**: _____ HMO or PPO?: _____

Vision: _____ Effective Date: _____

Policy/Group#: _____ **Phone Number**: _____ HMO or PPO?: _____

Does your Spouse have other insurance coverage?
Please provide a copy of Insurance Card [s] [front/back].

Medical	☐ Yes	☐ No
Dental	☐ Yes	☐ No
Vision	☐ Yes	☐ No

If yes, please indicate other insurance company name, address, telephone#, effective date, policy# and Subscriber name: _____

Medical: _____ Effective Date:_____

Policy/Group#: _____ **Phone Number**: _____ HMO or PPO?: _____

Dental:_____ Effective Date: _____

Policy/Group# _____ **Phone Number**: _____ HMO or PPO?: _____

Vision: _____ Effective Date : _____

Policy/Group# _____ **Phone Number**: _____ HMO or PPO ?: _____

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Phone 408-588-3753 • Toll Free 877-885-3753 • Fax 408-436-8210
www.ibew234benefits.org • staff@ibew234benefits.org

Do your dependents have any other coverage? Please indicate the coverage for your dependents below:

Dependents are classified as your natural children, legally adopted children, stepchildren or children from whom you have been appointed legal guardian by the court.

Please indicate the type of coverage available for each dependent.

Name of Dependents: (first and last name and relationship)

1._____ Medical? _____ Dental? _____ Vision? _____
2._____ Medical? _____ Dental? _____ Vision? _____
3._____ Medical? _____ Dental? _____ Vision? _____
4._____ Medical? _____ Dental? _____ Vision? _____
5._____ Medical? _____ Dental? _____ Vision? _____

If yes, please indicate other insurance company name, address, telephone#, effective date, policy# and Subscriber name: _____

Medical: _____ Effective Date: _____

Policy/Group#: _____ **Phone Number**: _____ HMO or PPO?: _____

Dental:_____ Effective Date: _____

Policy/Group# _____ **Phone Number**: _____ HMO or PPO?: _____

Vision: _____ Effective Date: _____

Policy/Group# _____ **Phone Number**: _____ HMO or PPO?: _____

Do you have legal custody and are you financially responsible for the covered children's medical, dental and vision bills?

☐ Yes ☐ No If no, please provide name and address of responsible party on reverse side. Please also provide the Trust Fund office with a copy of the following documents:

- € Copy of Divorce Decree and Court Documents
- € Signed/Notarized Affidavit of Custodial Parent
- € Copy of Legal Separation Documents
- € Proof of Support of Dependent

Please contact our office if you find any discrepancies with our records.

_____ _____

Signature of Subscriber **Date**