UFCW Local 1000 and Kroger Dallas Health & Welfare Plan
Coordination of Benefits Verification Form

Employee Name:		**Social Security Number:**		**Date of Birth:**	
				Phone #:	
Employee Mailing Address:				**Calendar Year this Form is for: (See Note on back page)**	

If you have other coverage for yourself for which you are the policyholder, please complete the following sections:

If you have other insurance coverage, please provide the requested information below.

Insurance Carrier Name:	Coverage Effective Date:
Insurance Carrier Phone #:	Policy Identification #:

If you have enrolled your spouse or children in the Plan, please complete the following sections:

Name of Spouse	**Date of Birth**	**SSN**	**Does your spouse have other Medical insurance coverage?**	**If your spouse has other <u>Medical</u> insurance coverage, please provide the requested information below.**	
			YES NO Please circle your response	Insurance Carrier Name:	Coverage Effective Date:
				Insurance Carrier Phone #:	Policy Identification #:

Name of Child	**Date of Birth**	**SSN**	**Does your Child have other Medical insurance coverage?**	**If your child has other <u>Medical</u> insurance coverage, please provide the requested information below.**		
			YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
			YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:
			YES NO Please circle your response	Insurance Carrier Name:		Coverage Effective Date:
				Insurance Carrier Phone #:	Policyholder Name:	Policy Identification #:

Employee Signature:
Spouse Signature:

I certify that the information provided on this annual verification form is true to the best of my knowledge and that the dependents I have enrolled meet the Plan's definition of Dependent as follows:

Dependent – The term "Dependent" means:

a. Your lawful spouse. The term "spouse" will only include the person to whom the Employee is married, and whose marriage has been solemnized and registered in accordance with the statutory law of jurisdiction in which the marriage occurred. The term will also include a common-law spouse if the Employee resides in a state that legally recognizes common-law spouses.
b. Your children under age 26 including legally adopted children, stepchildren, or children placed for adoption, and/or other children for whom the Employee is designated by a court of competent jurisdiction to be legal guardian.
c. Children who are incapable of self-sustaining employment because of a physical handicap or mental impairment, who are dependent on you for support and maintenance, provided his/her incapacity started prior to attaining the age at which his/her eligibility would otherwise terminate. However, the Dependent Life Insurance benefits do not apply to children above the age of 19 described in this provision.

The term Dependent will not include any person who is in full-time military, naval or air service.

IMPORTANT NOTE

This form must be filed with the Fund Office on an annual basis. If the Fund Office receives claims for you and/or your dependents and this form is not on file for the calendar year in which the claims were incurred, your claims will be denied and this form will be requested. If you submit the form within one year from the date it was requested, your claims will be reprocessed. If you do not submit the form within one year from the date it was requested, they will remain denied.

PLAN ADMINISTRATOR:

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