United Food & Commercial Workers Local 1000
Oklahoma Health & Welfare Fund "CARE-1000"

National Employee Benefits Administrators, Inc.
2010 N.W. 150th Avenue, Suite 100, Pembroke Pines, FL 33028
Phone 1-877-602-2733 Fax 954-266-2079

Annual Coordination of Benefits Verification Form

This form must be filed with NEBA on an annual basis. If NEBA receives claims for you and/or your enrolled 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 this form on a timely basis in accordance with the claims filing deadline under the UFCW Local 1000 Oklahoma Health and Welfare Fund "Care-1000" (the "Plan"), your claims will be reprocessed. Please review your Summary Plan Description for details regarding the claims filing deadline. **If you do not submit this form in accordance with the Plan's claims filing deadline, your claims will remain denied**.

You may return the form by mail or fax, at the address and fax number listed above, or by using NEBA's Secure File Upload or Encrypted Email Portal. Visit https://www.nebainc.com/SendFile.aspx to use the Secure File Upload. If you visit the site on your mobile device you can use your device camera to upload photos of the form pages. Photos must be clear enough to read and you must include a photo of all pages of the form. Visit https://luxsci.com/perl/public/securesend.pl and register to use the Secure Send Encrypted Email Portal. The portal allows you to create a free email account only for use in sending emails to NEBA in an encrypted fashion.

Employee Name:		**SSN:**		**Date of Birth:**	
				Phone #:	( )
Mailing Address:					
This Form applies to claims incurred in calendar year: *(You must complete one form for each calendar year)*				_____ *List calendar year*	

If you have enrolled your child(ren) in the Plan, please complete the following section:

Name of Child	**Date of Birth**	**SSN**	**Does your child have other group dental coverage?**	**If your child has other group dental coverage, please provide the requested information below.**		
1.			**YES NO** Please circle response	Group Dental Plan Provider Name:		Coverage Effective Date:
				Phone #:	Policyholder Name:	Policy Identification #:

Does your Child have other group medical coverage?	**If your child has other group medical coverage, please provide the requested information below.**		
YES NO Please circle your response	Group Medical Plan Provider Name:		Coverage Effective Date:
	Phone #:	Policyholder Name:	Policy Identification #:

Name of Child	**Date of Birth**	**SSN**	**Does your child have other group dental coverage?**	**If your child has other group dental coverage, please provide the requested information below.**		
2.			**YES NO** Please circle response	Group Dental Plan Provider Name:		Coverage Effective Date:
				Phone #:	Policyholder Name:	Policy Identification #:

Does your Child have other group medical coverage?	**If your child has other group medical coverage, please provide the requested information below.**		
YES NO Please circle your response	Group Medical Plan Provider Name:		Coverage Effective Date:
	Phone #:	Policyholder Name:	Policy Identification #:

Name of Child	Date of Birth	SSN	Does your child have other group dental coverage?	If your child has other group dental coverage, please provide the requested information below.		
3.			YES NO Please circle response	Group Dental Plan Provider Name:		Coverage Effective Date:
				Phone #:	Policyholder Name:	Policy Identification #:

Does your Child have other group medical coverage?	If your child has other group medical coverage, please provide the requested information below.		
YES NO Please circle your response	Group Medical Plan Provider Name:		Coverage Effective Date:
	Phone #:	Policyholder Name:	Policy Identification #:

Name of Child	Date of Birth	SSN	Does your child have other group dental coverage?	If your child has other group dental coverage, please provide the requested information below.		
4.			YES NO Please circle response	Group Dental Plan Provider Name:		Coverage Effective Date:
				Phone #:	Policyholder Name:	Policy Identification #:

Does your Child have other group medical coverage?	If your child has other group medical coverage, please provide the requested information below.		
YES NO Please circle your response	Group Medical Plan Provider Name:		Coverage Effective Date:
	Phone #:	Policyholder Name:	Policy Identification #:

Employee Signature:

I certify that the information provided on this annual form is true to the best of my knowledge and that the dependents I have enrolled meet the Plan's definition of "Dependent". I understand that it is my responsibility to notify NEBA of any changes that may impact my dependents' eligibility, such as a divorce.

Dependent means:

1. The Employee's child or children, including stepchildren, legally adopted children, children placed for adoption, or children for whom You have been appointed the legal guardian by a court of competent jurisdiction, if the adoption or placement occurs before the child reaches his or her eighteenth birthday, who:
   a. Has not reached the end of the month in which his or her 26th birthday occurs; or
   b. is incapable of self-sustaining employment because of a physical or mental handicap and is dependent on You for support and maintenance, provided his/her incapacity started prior to attaining the age at which his eligibility would otherwise terminate. However, children described in 2 (b) are not eligible for Dependent's Life Insurance, or
2. a child for whom coverage must be provided because of a Qualified Medical Child Support Order (QMCSO). A QMCSO is a court order, decree or a State administrative order that has the force and effect of law, relating to child support which provides for a child's coverage under the Plan's benefit program. To be qualified, the QMCSO must contain specific information and be submitted to the Fund Office.

The term Dependent will not include:

1. The Employee's spouse; or
2. any person who is in full-time military, naval or air service; or
3. any child whose non-custodial parent, if other than an eligible Employee, is required to contribute to his/her support by order of any court and is providing medical care protection for such child unless the child is named in a QMCSO. In that case, the child will be eligible for benefits in accordance with the order.

Employee Signature: _____ **Date:** _____