Plumbers & Pipefitters Local No. 421 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 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 #:

Please complete the following section pertaining to the Dental plan:

Name of Spouse	**Does your spouse have other Dental insurance coverage?**	**If your spouse has other <u>Dental</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	Does your Child have other Dental insurance coverage?	If your child has other Dental 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:

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 legal spouse

b. A Covered Employee's child(ren), or a Retiree's child(ren), from birth until the date upon which he/she attains twenty six (26) years of age.

c. The term "child" or "children" means a Covered Employee's natural child, Adopted Child, stepchild and/or foster child, as described in Section 152(f)(1) of the Internal Revenue Code. In addition, "child" also means a child for whom there is a Qualified Medical Child Support Order which states that health care coverage must be maintained by a Covered Employee or Retiree.

I understand that it is my responsibility to notify the Plan Administrator within 60 days of a divorce or legal separation from my spouse.

Employee Signature: _____ Date: _____

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:

NATIONAL EMPOYEE BENEFITS ADMINISTRATORS, INC. • 2010 NW 150TH AVENUE, SUITE 100 • PEMBROKE PINES, FL 33028
Telephone (954) 266-6322 • Toll Free (800) 842-5899 • Fax (954) 266-2079