

Roofers Local 195 Health & Accident Fund

(Complete separate forms for **each dependent** with **OTHER** coverage)

COORDINATION OF BENEFITS QUESTIONNAIRE

EMPLOYEE INFORMATION:

First:	Middle:	Last:	Suffix	SS#:
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SECTION 1: SPOUSE'S MEDICAL INFORMATION SPOUSE'S FULL NAME:

Is Your Spouse Medicare Eligible? <i>(Check One)</i>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No <i>(If no, Skip to Section 2)</i>
If yes, Medicare Effective Date is:				
Part A - ID #:				Part B - ID #:
				Part D - ID#:
If Under age 65, What is the Reason for Medicare Eligibility?				

SECTION 2: SPOUSE'S EMPLOYER INFORMATION

Is Your Spouse Employed? <i>(Check One)</i>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	Full Time	<input type="checkbox"/>	Part Time	<input type="checkbox"/>	No <i>(If No, Skip to Section 3)</i>
If yes, Name, Address & Phone Number of Spouse's Employer:								
Employer Name:	Employer Address						Employer Phone #	
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SECTION 3. OTHER MEDICAL INSURANCE COVERAGE INFORMATION (All Family Members)

Do You or Your Dependents have <u>OTHER</u> Medical Coverage?	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No <i>(if No, Skip to Section 4)</i>
Name of Dependent with <u>OTHER</u> Coverage?				Date of Birth:
Name of Policy Holder:	What Type of Coverage:		Family	Single
	Relationship to Policy Holder:			Group Number:
<u>OTHER</u> Insurance Covers: <i>(Check & Complete Applicable)</i>	Medical - ID#:		Dental - ID#:	
	Prescription - ID#:		Vision - ID#:	
Name, Address & Phone Number of <u>OTHER</u> Coverage(s)				
Carrier Name:	Carrier Address <i>(City, State, Zip)</i>			Carrier Phone #:
				()
Effective Date of Coverage:			Termination Date <i>(if applicable)</i> :	
<u>OTHER</u> Coverage is: <i>(Check one)</i>	Employer Sponsored Plan		Medicaid Plan	Other
Is Dependent Medicare Eligible? <i>(Check One)</i>	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No
Effective Date:				
Part A - ID#:	Part B - ID#:			Part D - ID#:
If Under age 65, What is the Reason for Medicare Eligibility?				

SECTION 4. SIGNATURE AND CONFIRMATION

I certify that the above information is true and understand that I may be held responsible for any overpayment made, on behalf of my dependent, due to misrepresented information.

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Employee Signature

Date

Phone Number

Under Federal Law, it is a crime to knowingly and willfully make a false statement in connection with the delivery, or payment, for health care benefits, or services (18 USC Sec. 1035). It is also a federal crime to attempt to defraud a health program, or knowingly and willfully steal, or otherwise convert money from, a health care fund (18 USC Sec. 669) (18 USC Sec 1347). These crimes are punishable by a fine, or imprisonment, or both.

Please submit copies of all Insurance Cards, Medicaid, and Medicare Cards, along with this completed form to:

Roofers Local #195 Fund Office, 6200 State Route 31, Cicero, New York 13039.

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SPOUSE'S EMPLOYER INSURANCE INFORMATION REQUEST FORM

If your spouse is employed, part or full-time, (s)he must have the following form completed and signed by his/her employer. If your spouse is not employed, please write "**Not Employed**" under the Spouse Insurance Information section below, sign the form at the bottom, and return to the Fund Office.

Member Information

Member Name: _____ Birthdate: _____
SS#: _____ Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone () _____ Cell Phone: () _____ Email: _____

Spouse Information

Spouse Name: _____ Birthdate: _____
SS#: _____ Street Address: _____
City: _____ State: _____ Zip Code: _____
Phone () _____ Cell Phone: () _____ Email: _____

Spouse Employer Information – EMPLOYER MUST COMPLETE THIS SECTION

Spouse's Employer Name: _____ Employer Phone: () _____
Employer Street Address: _____ City: _____ State: _____ Zip: _____
Supervisor's Name: _____ Phone: () _____
Employer Fax: () _____

Does your company offer Medical Insurance Benefits to their employees? Yes _____ No _____
Is this employee eligible for these benefits through your company? Yes _____ No _____
Is this Employee currently enrolled in your Medical Insurance Plan? Yes _____ No _____

If Yes, Effective Date of Coverage: _____ If No, why? _____

What is the date of your next open enrollment, or enrollment period? _____

Does your company offer an "Opt-out" incentive program? Yes _____ No _____

Is your Medical Insurance Plan employer contributed? Yes _____ No _____

If yes, what %? _____

What is the cost per month to the employee for **Self-Only Medical** Insurance? \$ _____ /month

What is the Gross pay of the employee per month? \$ _____ /month

(attached proof – recent paystub or W-2 from previous year)

What type of Medical coverage is offered to your employee? ___ Family _____ Self

Employer Signature: _____ Title: _____

Employer Printed Name: _____ Date: _____

The Fund Office reserves the right to request updated employment information and/or proof of health insurance availability at any time. Any person who knowingly, and with intent to defraud the Roofers Local #195 Health & Accident Fund, files a false statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime. Per the Summary Plan Description Booklet when a participant's spouse has health insurance or expense benefits available to him/her under his/her employer's plan, there will be no coverage under this benefit Plan, unless such spouse enrolls in his/her employer's plan. We will then coordinate benefits with the spouse's employer plan as a secondary payer.

An exception will be considered if the cost for his/her enrollment is substantial (**more than 10% of her/his gross pay**). Note that if he/she is enrolled in his/her employer's plan, coordination with that plan will take place, in the event of a claim with his/her plan paying first. **If the spouse fails to enroll in his/her plan**, when there is no exception granted based on cost, the Plan will coordinate benefits as if the Spouse were enrolled in their employers plan. The Fund Office has the right to require submission of the spouse's employer plan documents to coordinate these benefits. **Failure to submit required documentation will result in denial of claims.**

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