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#:

SECTION 1: SPOUSE'S MEDICAL INFORMATION

Is Your Spouse Medicare Eligible? *(Check One)*		Yes		No *(If no, Skip to Section 2)*
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? *(Check One)*		Yes		Full Time		Part Time		No *(If No, Skip to Section 3)*
If yes, Name, Address & Phone Number of Spouse's Employer:								
Employer Name:	Employer Address						Employer Phone # ( )	

SECTION 3. OTHER MEDICAL INSURANCE COVERAGE INFORMATION (All Family Members)

Do ***You or Your Dependents*** have **OTHER** Medical Coverage?		Yes		No *(if No, Skip to Section 4)*
Name of Dependent with **OTHER** Coverage?				Date of Birth:
Name of Policy Holder:	What Type of Coverage:		Family	Single
	Relationship to Policy Holder:			Group Number:
OTHER Insurance Covers: *(Check & Complete Applicable)*	Medical - ID#:		Dental – ID#:	
	Prescription - ID#:		Vision – ID#:	
Name, Address & Phone Number of **OTHER** Coverage(s)				
Carrier Name:	Carrier Address *(City, State, Zip)*		Carrier Phone #: ( )	
Effective Date of Coverage:	Termination Date *(if applicable)*:			
OTHER Coverage is: *(Check one)*	Employer Sponsored Plan	Medicaid Plan	Other	
Is Dependent Medicare Eligible? *(Check One)*	Yes	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.

( )

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, 7706 Maltlage Drive, Liverpool, NY 13090.

Roofers Local 195 Health & Accident Fund

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

SPOUSE 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 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

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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