JEZELI SA JAKIEKOLWIEK PYTANIA DOTYCZACE TEJ FORM PROSZE TELEFONOWAC DO: CLAIM DEPARTMENT (312) 233-8899

COORDINATION OF BENEFITS QUESTIONNAIRE FOR DEPENDENT CHILDREN AGES 18-25

IMPORTANTE: SI NECESITAN MAS INFORMACION ACERCA DE ESTE IMPRESO, LLAMEN A LA DEPARTAMENTODE RECLAMACIONES (312) 233-8899

PLEASE PRINT INFORMATION AND RETURN TO:

SEIU Local 1 & Participating Employers Health Trust

CLAIM DEPARTMENT

111 EAST WACKER DR. • 17th FLOOR • CHICAGO, ILLINOIS 60601 • TELEPHONE (312) 233-8899

This form must be completed in **full** for each new claim filed with this office. Upon completion, please attach your bills to it and return to us.

PART I—TO BE COMPLETED BY EMPLOYEE

Employee's Name:__________ Area Code_____ Phone No._____

Home Address:__________ City_____ State_____ Zip_____

SSN or **Alternate Identification #:**_____ Birth Date:_____ Sex:_____

Employer:__________ Phone No.:_____

Address:__________ City:_____ State:_____ Zip:_____

Patient Information: Child's Name__________ Date of Birth _____ Sex _____

IMPORTANT — THIS SECTION MUST BE COMPLETED — FAILURE TO COMPLETE THIS SECTION WILL ONLY DELAY THE PROCESSING OF THIS CLAIM.

Employee's Spouse Name:__________ Date of Birth_____

Does employee's spouse have insurance through his or her employer? ❑ Yes ❑ No

Name of employer sponsoring other insurance__________

Name of employee belonging to other group__________

Group Policy No. and/or Subscriber No.__________

Full name and phone number of the other insurance:__________

____

(If above answered YES please be sure to send copies of the same bills to the other company.)

I hereby certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true, correct, and complete.

Employee Signature:__________ Date:_____

CLAIM CANNOT BE PROCESSED WITHOUT YOUR SIGNATURE

All benefits provided under this Plan are automatically assigned to the provider of service unless a paid in full receipt is furnished to the Claim Office when Claim is made.

-PLEASE COMPLETE BOTH SIDES OF THIS FORM-

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II. INFORMATION ABOUT CHILD

1. Full Name of Child: ______________________

2. Social Security Number: ______________________

3. Child's Date of Birth: ______________________
   Month Day Year

4. Sex: ❑ Male ❑ Female

5. Child's Address: ______________________
   (If different that yours) Street
   ____
   City State Zip

6. Is child employed? ❑ Yes
   ❑ No - If no, please answer question 8.

7. Did child elect health care coverage through his or her employment? ❑ Yes ❑ No
   If yes, coverage effective date: ______________________
   Full name and phone number of the other insurance: ______________________

8. Is child ❑ Single ❑ Married - If married, please answer question 9.

9. Is child's spouse employed? ❑ Yes – If employed, please answer question 10.
   ❑ No

10. Did child elect health care coverage through his or her spouse's employment? ❑ Yes ❑ No
    If yes, coverage effective date: ______________________
    Full name and phone number of the other insurance: ______________________

III. SIGNATURE

I affirm that if this child is age 18-25 he or she is not enrolled in any health care coverage offered by the child's or child's spouse's employer and that if he or she becomes enrolled in such coverage in the future, I will inform the Fund within 30 days. I further afirm that the information given on this form is true and correct to the best of my knowledge.

______________________ ______________________
Employee's Signature Date

–PLEASE COMPLETE BOTH SIDES OF THIS FORM–