COORDINATION OF BENEFITS QUESTIONNAIRE
FOR
DEPENDENT CHILDREN AGES 18-25

PLEASE PRINT INFORMATION AND RETURN TO:

SEIU Local 1 & Participating Employers Health Trust

CLAIM DEPARTMENT

200 EAST RANDOLPH STREET • SUITE 1500 • 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_____

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

Spouse's Name:_____ Date of birth___

Does your 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 the 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.

COORDINATION OF BENEFITS QUESTIONNAIRE

FOR

DEPENDENT CHILDREN AGES 18-25

PLEASE PRINT INFORMATION AND RETURN TO:

:

SEIU Local 1 & Participating Employers Health Trust

CLAIM DEPARTMENT

200 EAST RANDOLPH STREET • SUITE 1500 • CHICAGO, ILLINOIS 60601 • TELEPHONE (312) 233-8899

II. INFORMATION ABOUT CHILD

1. Full name of Child:_____
2. Social Security Number:_____
3. Child's Date of Birth:_____
4. Sex: Male_____ Female_____
5. Child's Address_____
   (If different from yours) Street
   _____
   City State Zip
6. Is the 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 affirm that the information given on this form is true and correct to the best of my knowledge.

Employees Signature:_____**Date**_____