EMPLOYERS & OPERATING ENGINEERS LOCAL 520

COORDINATION OF BENEFITS FORM 2009-2010 COVERAGE PEIROD

All employees who have family members covered under their health plan will be required to provide the following information:

Failure to complete this form may result in claim processing delays.

Do you or any of your family members have other group health coverage? ☐ No ☐ Yes
Is this health coverage provided by a Past or Present Employer? ______ Who is the insured member? ______
Provide the Fund Office with a copy of the front and back of this insurance card. ☐ ☐
Do you or any of your family members have coverage through Medicare? ☐ No ☐ Yes
If you answered NO, skip to signature and date at the bottom of this form and return to:

Employers & Operating Engineers Local 520, #8 Executive Woods Court, Swansea, IL 62226

Or Fax to 618-233-7716. **If this information should change, please contact our office at 618-233-7978.**

If you answered YES, complete the remainder of this form, with respect to each family member, and return to the above address.
(If additional space is needed, please attach additional page)

Does other insurance apply?

Local 520 Member Name: ______ Social Security #: ______ ☐ No ☐ Yes
Effective Date of Coverage: ______ Group/Policy #: ______
Insurance Company Name: ______ Telephone: ______
Termination Date of Other Coverage (if terminated within the past 12 months): ______
Are Dental Benefits Provided? ☐ Yes ☐ No **Include Certificate of Creditable Coverage Provided by this Carrier**
Are Optical Benefits Provided? ☐ Yes ☐ No

Spouse Name: ______ Social Security #: ______ ☐ No ☐ Yes
Effective Date of Coverage: ______ Group/Policy #: ______
Insurance Company Name: ______ Telephone: ______
Termination Date of Other Coverage (if terminated within the past 12 months): ______
Are Dental Benefits Provided? ☐ Yes ☐ No **Include Certificate of Creditable Coverage Provided by this Carrier**
Are Optical Benefits Provided? ☐ Yes ☐ No

Dependent Name: ______ Social Security #: ______ ☐ No ☐ Yes
Effective Date of Coverage: ______ Group/Policy #: ______
Insurance Company Name: ______ Telephone: ______
Termination Date of Other Coverage (if terminated within the past 12 months): ______
Are Dental Benefits Provided? ☐ Yes ☐ No **Include Certificate of Creditable Coverage Provided by this Carrier**
Are Optical Benefits Provided? ☐ Yes ☐ No

Dependent Name: ______ Social Security #: ______ ☐ No ☐ Yes
Effective Date of Coverage: ______ Group/Policy #: ______
Insurance Company Name: ______ Telephone: ______
Termination Date of Other Coverage (if terminated within the past 12 months): ______
Are Dental Benefits Provided? ☐ Yes ☐ No **Include Certificate of Creditable Coverage Provided by this Carrier**
Are Optical Benefits Provided? ☐ Yes ☐ No

Dependent Name: ______ Social Security #: ______ ☐ No ☐ Yes
Effective Date of Coverage: ______ Group/Policy #: ______
Insurance Company Name: ______ Telephone: ______
Termination Date of Other Coverage (if terminated within the past 12 months): ______
Are Dental Benefits Provided? ☐ Yes ☐ No **Include Certificate of Creditable Coverage Provided by this Carrier**
Are Optical Benefits Provided? ☐ Yes ☐ No

______ Signature of Employee ______ Employee Social Security Number ______ Date