

2. Employer Health Plan

Can your young adult dependent receive health insurance through his/her employer? Yes No

If they can, do they currently receive it? Yes No

Please provide the following information:

• Employer's Full Name: _____

• Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Please Indicate the Type of Coverage (Check all that apply):

Medical Hospital Prescription Dental Vision

Effective Date of Coverage: _____ / _____ / _____
Month Day Year

• Name of Insurance Plan: _____

Policy/Group #: _____

Insurance Plan Telephone: _____ - _____ - _____

3. Spousal Health Plan

Does your young adult dependent receive health insurance through his/her spouse's employer? Yes No

If yes, please provide the following information:

• Spouse's Full Name: _____

Spouse's Date of Birth: _____ / _____ / _____
Month Day Year

• Employer's Full Name: _____

• Employer's Address: _____

City: _____ State: _____ Zip Code: _____

Please Indicate the Type of Coverage (Check all that apply):

Medical Hospital Prescription Dental Vision

Effective Date of Coverage: _____ / _____ / _____
Month Day Year

• Name of Insurance Plan: _____

Policy/Group #: _____

Insurance Plan Telephone: _____ - _____ - _____

This coordination of benefits form is for Fund use only, and it will not be released to any third party except where necessary for the administration and operation of the Fund, or where otherwise required by law. The foregoing statements are to the best of my knowledge true and complete. I authorize any hospital, physician or other healthcare provider to release to the Fund and its agents any records of information, without restriction, concerning me or any member of my family receiving benefits from the Fund. Unless I revoke it in writing, this authorization will be effective as long as I am a participant in the Fund. A photocopy of this authorization shall be as valid as the original. I understand that under the terms of the plan (SPD), the Fund has a right to be reimbursed for any money it pays on my behalf for expenses caused by a third party. If the Fund pays any such claims, it will have a lien on payments I receive from, or on behalf of, the third party, and I agree to pay back the Fund for any payments it has made. This agreement will be effective for all benefits incurred while I am a participant in the Fund, even if I receive payments from, or on behalf of, a third party when I am no longer a participant.

I certify that the foregoing is true and correct.

Member's Signature X _____ **Date:** _____

Failure to respond will create a gap in coverage for the young adult dependent.