WESTCHESTER PUTNAM COUNTIES HEAVY & HIGHWAY LABORERS
BENEFIT FUNDS
PENSION - WELFARE - ANNUITY - LEGAL - TRAINING
LOCAL 60
140 BROADWAY
HAWTHORNE, N.Y. 10532
Tel: (914) 769-2440
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Union Trustees
Anthony Ascencao
Richard Berardo
Augusto Rosa

Employer Trustees
Ross Pepe
George Pacchiana

2015 COORDINATION OF BENEFITS FORM

Plan Participant, the Westchester Putnam Counties Heavy & Highway Laborers Local 60 Health & Welfare Plan has a Coordination of Benefits (COB) rule in order to determine whether your dependent(s) has other insurance coverage. If you are married or have dependent children, it is your responsibility to return this form to the fund office. If you are married or have an ex-spouse and dependent children, you are required to return this form before any claims will be paid on your dependents behalf. **If the fund office receives a claim(s) for your dependent(s) before you return this completed form, the claim(s) will be denied until this information is completed and returned.**

Please answer the questions below:

Is your spouse or ex-spouse employed? ☐ Yes ☐ No

Is your spouse or ex-spouse covered by any other insurance plan? ☐ Yes ☐ No

Do you want to continue coverage for your dependents 19-26 years old (If applicable)? ☐ Yes ☐ No

If you indicated "YES" to any of the questions above, you must complete the following:

Spouse's Name_____ **SS#**_____ **DATE OF BIRTH:** _____

Dependent's Name_____ **SS#**_____ **DATE OF BIRTH:** _____

Dependent's Name_____ **SS#**_____ **DATE OF BIRTH:** _____

Spouse's Insurance information (other than Local 60 Health & Welfare Plan):

Hospital: ☐ Yes ☐ No Effective Date: _____ Policy#: _____

Medical: ☐ Yes ☐ No Effective Date: _____ Policy#: _____

Dental: ☐ Yes ☐ No Effective Date: _____ Policy#: _____

Prescription: ☐ Yes ☐ No Effective Date: _____ Policy#: _____

Optical: ☐ Yes ☐ No Effective Date: _____ Policy#: _____

Indicate Individual or Family coverage: _____

Insurance Carrier's name, address & phone number: _____

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NOTE: A COORDINATION OF BENEFITS FORM MUST BE COMPLETED EACH CALENDAR YEAR.

PLEASE READ AND SIGN: I understand that if I knowingly defraud, conceal or provide false information for the purpose of misleading the Fund, my eligibility for Fund coverage will be terminated and I will be liable for any claims that were paid based on the false or misleading information. Your signature indicates that the information on this form is correct.

_____ _____

Signature of Member **Date**

Member's Alternate I. D. Number: M2453000 ☐☐☐☐ OR: SS#: _____