COORDINATION OF BENEFITS INFORMATION

SECTION 1 YOUR MICHIGAN CONFERENCE OF TEAMSTERS WELFARE FUND INFORMATION

Participant Name (as found on your ID card)	Participant Contract ID

Have you, your spouse or your dependents been covered by other group health insurance or Medicare in the past year?

☐ NO – Please skip the rest of the questions, sign the bottom of this form, and return to MCTWF.

☐ YES – Please complete the entire form, sign the bottom of this form, and return to MCTWF.

SECTION 2 OTHER GROUP HEALTH INSURANCE INFORMATION

Please provide the following information about the cardholder of the other group health insurance as it appears on his or her ID card. If more than one other group health insurance exists, please attach additional pages as needed with the same required information.

Cardholder Name	Relationship to you	Date of Birth

Other Group Health Insurance Name	Phone Number	Policy Number

Type of Medical Plan:	☐Medicare / Medigap ☐Medicaid ☐COBRA Policy	☐Group Health ☐Individual Policy ☐Retiree Policy	Effective Date of Coverage	Termination Date (attach carrier letter)

Type of coverage: (check all that apply)	☐Medical ☐Dental	☐Vision ☐Prescription Drugs	Employer

Who is covered by this other group health insurance? Include yourself if applicable.

	Name (first and last)	Relationship to You	Date of Birth
1.			
2.			
3.			
4.			

SECTION 3 SPECIAL SITUATIONS

Fill out this section only if your children have other group health insurance in addition to the above in Section 2 because of divorce, separation or court order.

Is there a court order that determines responsibility for health care coverage or custody? ☐ Yes ☐ No (attach a copy of the sections that apply to health care responsibility and/or custody arrangements)

Name of person responsible for child's health care coverage	Employer	Date of Birth

Other Group Health Insurance Name	Phone Number	Policy Number

Type of Medical Plan:	☐Medicare / Medigap ☐Medicaid	☐Group Health ☐Individual Policy	Effective Date of Coverage	Termination Date (attach carrier letter)

SECTION 4 MEDICARE COVERAGE

Fill out this section only if you, your spouse or your dependents are eligible for Medicare insurance coverage.

Name of Person Eligible for Medicare	Date of Birth

Is this Medicare Coverage due to End Stage Renal Disease (ESRD)? ☐ Yes ☐ No

1st Date of Dialysis:	If Medicare is due to other disability, please include a brief description:

I understand that if I do not provide complete and accurate information or do not promptly notify MCTWF of changes in information, my benefits may be suspended until I have provided complete and accurate information to MCTWF, and MCTWF will seek recovery from me for benefits paid in error.

Participant Signature: ________________________________ Date:__________________

Return completed form to:

Michigan Conference of Teamsters Welfare Fund
2700 Trumbull Avenue
Detroit, Michigan 48216
(800) 572-7687
Fax Number: (313) 496-2933
www.mctwf.org