Professional Benefit Administrators

DATE

Name

Address

City, State Zip

Group: North Central IL Laborers' Health & Welfare Fund
Group #: 070613
Employee:
Division #:
Claimant:
Claim #:
Provider:
Service Dates:

We are in receipt of the above referenced claim. The Plan in which you and your dependent(s) are covered contains a Coordination of Benefits provision that makes it necessary for us to periodically request new and/or updated information as it relates to the possibility of other insurance coverage. Please answer the following questions and return this form to us as quickly as possible to prevent further delay in the processing of your claim and ensure proper benefit payment.

1. Is your spouse employed? ☐ Yes ☐ No ☐ Does not apply

   If yes, is your spouse eligible for coverage through his/her Employer? ☐ Yes ☐ No

   If yes, did your spouse elect insurance coverage through his/her Employer? ☐ Yes ☐ No

   If yes, please complete the following:

   Spouse ID#: _____

   Spouse Name and Date of Birth: _____

   Employer Name/Phone: _____

   Employer Address: _____

   Insurance Company Name: _____

   Insurance Company Phone #: _____ Plan#: _____

   Is this an HMO policy? ☐ Yes ☐ No

   If your spouse no longer has other coverage please provide the termination date: _____

Coverage: (Mark all that apply)

☐ Medical	☐ Single	☐ Family	Effective Date _____
☐ Dental	☐ Single	☐ Family	Effective Date _____
☐ Vision	☐ Single	☐ Family	Effective Date _____
☐ Drug Card	☐ Single	☐ Family	Effective Date _____

2. Please list all family members covered under the other insurance coverage. If more than one insurance carrier exists, list the name, address, phone number and group/plan number of the other insurance carrier(s):

3. Are you and/or your dependents Medicare eligible? ☐ Yes ☐ No

   If yes, please list who is eligible and the reason (Age 65 or older, Disabled under age 65, End Stage Renal Disease or Disabled ESRD:

   _____

   Effective Date for: _____ Medicare Part A
   _____ Medicare Part B
   _____ Medicare Part D

4. Do you have a dependent child covered under this plan and someone else has financial responsibility?
   ☐ Yes ☐ No ☐ Does not apply

   If yes, indicate who and under what circumstances:

   If yes, please send us a copy of the page(s) from the legal document (court decree, divorce decree, etc.) that validates this requirement. If you have already submitted these legal documents, you may disregard this request.

CERTIFICATION: I certify that these statements and answers are true to the best of my knowledge and belief.

Please sign and return.

Employee Signature: _____ Date: _____

Print Name: _____

Thank you for helping us serve you better. Please return this completed form in the enclosed envelope or fax to 630-286-4601.

Claim Department
Professional Benefit Administrators