Heat & Frost Insulators Local 17 Benefit Funds

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Dear Member:

Your Local 17 Plan Doc contains Coordination of Benefit Rules. The processing of your health claims is dependent upon your response. ***THIS FORM MUST BE RETURNED TO THE FUND OFFICE WITHIN 30 DAYS, IF IT IS NOT RETURNED IT WILL DELAY ALL CLAIMS PROCESSING***.

Are you or any member of your family, that is currently eligible for benefits, covered by another health, dental and/or optical insurance policy or Medicare?

___ No If "No" was checked, please complete box below, sign and return questionnaire to us.
___Yes If "Yes" was checked, please complete all of the following:

a. **Check all that apply:**
___ Health ___ Dental ___ Optical ___ Group Coverage (employment or professional organization)
___ Individual Policy ___ Student Policy ___ Sport Policy
___ Medicare Part A and/or Part B ___ Other ____________________

b. **Other Insurance Carrier's Name:** ________________________________ Policy #________________
Address: ____
City, State, Zip Code: ______________________________ Phone: (_____) _______-__________

c. **Other Insurance Policy holder's name:** ____________________ Policyholder's birthdate: __________

d. **Other Insurance Employer's name:** ____
Employer's Address: ____
City, State, Zip Code: ______________________________ Phone: (_____) _______-__________

If necessary, use a separate piece of paper to list any additional policies.

Please complete the following information for all family members covered by Local 17 Welfare Fund.

Name (first and last)	Birthdate MMDDYYYY	Social Security # and HIC # (if applicable)	Medicare/other Ins. Effective Date	Reason(s) for Entitlement*	Medicare/Other Ins. Cancel Date
Member			Part A Part B		Part A Part B
Spouse			Part A Part B		Part A Part B
Dependent			Part A Part B		Part A Part B
Dependent			Part A Part B		Part A Part B
Dependent			Part A Part B		Part A Part B

*The Reason for Medicare Entitlement should be: Attaining age 65, Disability, or End Stage Renal Disease.

Please respond by using the enclosed envelope, the Fund Office appreciates your prompt reply.

Member's Signature: ______________________________ Date: ______________________

Print Name: ______________________________