Coordination of Benefits Form for Young Adult Coverage

Instructions: Complete a separate Coordination of Benefits Form for Young Adult Coverage for each dependent child from age 19 up to age 26 for whom you are requesting Benefit Fund coverage. Please print clearly in blue or black ink and place one character per box.

1199SEIU Benefit and Pension Funds Member Eligibility Department PO Box 1035 New York, NY 10108-1035

Member's Information Member's Full Name: ______ Benefit Fund (NBF or GNY): _____ Member ID: Address: State: _____ Zip Code: ___ Citv: Home #: | | | |-| | | |-| | | | Cell #: | | | |-| | | |-| | | Email Address: | | | | | | | Young Adult's Information Dependent's Full Name: Sex: | | M Social Security #: XXX-XX-Zip Code: | | | | Cell #: L__ Email Address: Please indicate in the following sections if your young adult can receive health insurance through another source. Fill out all that apply: 1. Other Parent's Health Plan Can your young adult dependent receive health insurance through his/her other parent's employer? | Yes L____ No If ves, please provide the following information: Parent's Full Name: _____ Employer's Full Name: _____ | __ | __ | __ | __ | __ | Employer's Address: _____ | ___ | | | | | | Please Indicate the Type of Coverage (Check all that apply): L____ Hospital ____ Medical ____ Prescription ____ Dental | | Vision Effective Date of Coverage: | Name of Insurance Plan:

Policy/Group #: L_____

2. Employer Health Plan
Can your young adult dependent receive health insurance through his/her employer? L Yes L No
If they can, do they currently receive it? L Yes L No
Please provide the following information:
• Employer's Full Name:
• Employer's Address:
City: Zip Code: Zip Code:
Please Indicate the Type of Coverage (Check all that apply):
Medical Hospital Prescription Dental Vision
Effective Date of Coverage://
Name of Insurance Plan:
Policy/Group #:
Insurance Plan Telephone: L
3. Spousal Health Plan
Does your young adult dependent receive health insurance through his/her spouse's employer?
If yes, please provide the following information:
Spouse's Full Name:
Spouse's Date of Birth: / /
• Employer's Full Name:
Employer's Address:
City: Zip Code: Zip Code:
Please Indicate the Type of Coverage (Check all that apply):
Medical Hospital Prescription Dental Vision
Effective Date of Coverage://
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 rec 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 recoinformation, 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 partic 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 be
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 and the such that the fund for any payments I receive payments from, or on behalf of, a third party when I am no longer 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 in the Fund, even if I receive payments from the fund party when I am no longer a participant in the Fund, even if I receive payments from the fund party when I am no longer a participant in the Fund, even if I receive payments from the fund party when I am no longer a participant in the fund par
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.