TEAMSTERS LOCAL 639 – EMPLOYERS HEALTH FUND

PO Box 99489
Troy, MI 48098-9998

(202) 636-8181
(800) 983-2699 - Phone
(202) 526-7959 – Fax

Dear Participant:

To protect itself from assuming the responsibility for paying claims that should be paid by another medical plan, the Teamsters Local 639 - Employers Health Trust Fund ("Fund") has "Coordination of Benefits" rules. These rules help to assure that the Fund does not pay benefits that should be paid by another group health plan. In order to ensure that this provision is correctly administered, we need to know if you or your dependents (spouse and/or child(ren)) have other health coverage.

If you have any questions, please contact the Fund's Membership Services Department at (202) 636-8181, Monday through Friday from 9:00 AM until 5:00 PM.

Section 1 – Coordination of Benefits

Do you or any of your dependents have coverage under *any* group health plan (Medicare, employer sponsored health coverage, school insurance, etc.) other than the Fund?

_____ **Yes** Please complete *all four* sections and then return this form to the Fund's address noted above.

_____ **No** Please complete section 2 and then return this form to the Fund's address noted above.

Section 2 – Member Certification (To be Completed By All Members)

I hereby certify that the information on this form is true and correct and agree to notify and inform the Fund of any changes.

Member Name: _____ Social Security Number: _____

Date of Birth: _____ Phone Number: _____

Are you retired? ____ No ____ Yes Date of Retirement? _____

Signature: _____ Date: _____

(OVER)

Section 3 – Other Health Plan Coverage Information

Please provide this information for each group health care plan, other than Medicare, covering either you or your dependents.

Health Plan Information

Subscriber's Name: _____ Social Security Number: _____

Date of Birth: _____ This is an: ❑Active Policy ❑Retiree Plan ❑COBRA Plan

Covered Persons: _____

Name of Insurance Company: _____

Address of Insurance Company: _____

Company's Phone Number: _____ Effective Date: _____

Policy Number: _____ Group/Plan Number: _____

Section 4 – Medicare Coverage Information

Please provide this information for each individual on your policy covered by Medicare. Please write N/A or none if this section does not apply to anyone on your policy.

Name: _____ Medicare ID Number: _____

Effective Date: _____ Part A (Hospital) Reason Eligible: ____ Age
_____ Part B (Medical) ____ Disability
_____ Part D (Drug) ____ End Stage Renal Disease

Name: _____ Medicare ID Number: _____

Effective Date: _____ Part A (Hospital) Reason Eligible: ____ Age
_____ Part B (Medical) ____ Disability
_____ Part D (Drug) ____ End Stage Renal Disease

Please include a copy of your and/or your spouse's Medicare card, if applicable, with this form.