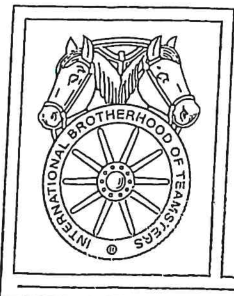

TEAMSTERS UNION LOCAL NO. 35

SERVICE, INDUSTRIAL AND PROFESSIONAL EMPLOYEES

HEALTH PLANS

620 U.S. ROUTE 130 TRENTON, NEW JERSEY 08691 (609) 585-3600 FAX: (609) 585-3929

MEMBER NAME____________________
MEMBER ID #______________________
GROUP #_________________________

Dear Member,

Your Teamsters Local 35 Health Plans contains a Coordination of Benefits (COB) provision. COB applies when a member has more than one health insurance policy. The COB provision helps to ensure that covered services are reimbursed under the primary policy first and that any remaining member liability is reimbursed, in order, by any other policies in effect.

Regardless of whether you have a health insurance policy other than your Teamsters Local 35 Health Plans, please provide the information requested below.
*** CLAIMS WILL NOT BE PAID UNTIL THIS INFORMATION IS RETURNED TO US ***

You may return this information to us by:

- Completing this letter and form and fax it to: 609-585-3929 / Email: lori@teamsters35.com
- Completing this letter and form and mailing it to: Teamsters Local 35 Health Plans
  620 US Route 130
  Trenton, NJ 08691

When no other coverage exists, claims denied for COB information will be reprocessed after the file update is complete. If you have questions or would like to discuss your benefits, please call the Fund office at 1-609-585-3600.

Sincerely,
Teamsters Local 35 Health Plans

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OTHER THAN YOUR CURRENT TEAMSTERS LOCAL 35 HEALTH PLANS
DO YOU OR A COVERED DEPENDENT HAVE ANY OTHER HEALTH COVERAGE.
INCLUDING MEDICARE COVERAGE, PRESCRIPTION, DENTAL OR VISION COVERAGE.

○ NO (If No, please sign below and return this page to Teamsters Local 35 Health Plans.)

○ YES (If Yes, please sign below, complete the reverse side of this form and include any Medical, Prescription, Dental & Vision Coverage). Please return form to Teamsters Local 35 Health Plans.

To the best of my knowledge, I certify that the above stated information is complete and accurate.

______________________________ ____________________
Subscriber Name / Phone Date

Teamsters Local 35 Health Plans Co-ordination of Benefits information

Please complete all of the sections below

Section I: This section applies to you or your dependants other group health plan coverage.

Name of policy holder: ______________________ Policy Holder's Date of Birth: __________

Name of Employer: ______________________

Teamsters Local 35 Health Plan ID #: ______________________

Employer's Address ______________________

Insurance Carrier Name: ______________________

Address of Insurance Carrier: ______________________

Insurance Carrier Phone Number: __________ Group policy number: __________

Policy Holder ID Number: ______________ Effective Date __________ Cancel Date: __________

Type of Coverage: ◯Single ◯Two adults/Married ◯Family ◯Parent/Child __________

List all Dependent(s) covered under this policy

Name: ______________________ DOB: __________

Name: ______________________ DOB: __________

Name: ______________________ DOB: __________

Section II: This section applies if you or a covered dependant has Medicare coverage.

Name of Medicare Beneficiary: ______________________

Medicare ID Number: ______________________

Effective Dates: Medicare Part A __________ Medicare Part B __________

Medicare Part C __________ Medicare Part D __________

Medicare Entitlement: ◯ Age ◯ Disability ◯ End Stage Renal Disease (ESRD)

Date of Disability: __________ Date of First ESRD Treatment: __________

First ESRD Treatment performed in a facility? ◯ Yes ◯ No

Section III: This section applies if you have dependant children covered under your policy.

Is there a court order regarding health care coverage for your children? ◯ Yes ◯No

If the answer is Yes, please answer the questions below and supply us with a copy of the Medical Child Support Order

Who is the person(s) listed in the court order to maintain health coverage for your children?

Parent/Guardian: ______________________ Parent/Guardian DOB: __________

Parent/Guardian: ______________________ Parent/Guardian DOB: __________

List all dependant(s) to whom the court order applies.

Name: ______________________ DOB: __________

Name: ______________________ DOB: __________

Name: ______________________ DOB: __________

Has the custodial parent remarried? ◯ Yes ◯No

Name of new spouse? ______________________ DOB: __________

Are there any exceptions to the court order? ◯ Yes ◯No

If Yes, please explain:

____

____

____

To the best of my knowledge, I certify that the above stated information is complete and accurate.

Teamsters Local 35 Health Plans ID Number; ______________________

Member Signature: ______________________ **Date:** __________

Please provider a number at which we may call you if we need additional information: __________