MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND
PO BOX 1501•1400 DISTRICT AVENUE
BURLINGTON, MASSACHUSETTS 01803-1501
TELEPHONE (781) 272-1000 • TOLL FREE (800) 342-3792 • FAX (781) 238-0703

Coordination of Benefits Questionnaire

Member Name
Address
City, State

MLBF ID: _____

The Massachusetts Laborers' Health & Welfare Fund contains a coordination of benefits provision. We depend upon your help in order for us to process your claims correctly. We appreciate your prompt and accurate reply. If any of the information below changes, please contact the Fund office immediately.

Please complete this Form and return to the Health Fund as soon as possible in order to avoid nonpayment of medical claims for your dependents.

Are you or any member of your family covered by another health care policy, including Medicare?

☐ YES, If yes, please complete all of the applicable fields below

☐ NO, If no please sign and date the bottom of this form

Section A

- **Please attach a copy of your other insurance card**

Other Insurance Name:	Member ID#
Other Insurance Address and phone number:	
Policy Holder's Name:	Effective Date:

Type of coverage: ☐ Single ☐ Family ☐ Single + One

List dependents covered on other plan:

Name:	Date of Birth:	Relationship to Insured:

MASSACHUSETTS LABORERS' HEALTH AND WELFARE FUND

Coordination of Benefits Questionnaire

Section B If this does not apply, skip to Section C

Medicare Information:

Are you or any of your dependents eligible for Medicare Coverage? ☐ YES ☐ NO

Name of person with Medicare: _____

Medicare Number, including alpha character: _____

Part A Effective Date: ____/____/_____ Part B Effective Date: ____/____/_____

Entitlement Reason: ☐ Age ☐ Disability ☐ End Stage Renal Disease (ESRD)*

*If reason is ESRD, please provide the 1st date of dialysis: ____/____/_____

Section C If this does not apply, please sign, date, and submit form

Court Order Information:

Are you divorced or legally separated from the other policy holder in section A? ☐YES ☐NO

Is there a court order specifying a person to maintain health coverage for your dependents? (If yes, please provide a copy of the court order.) ☐YES ☐NO

If yes, who is the person listed to maintain coverage: _____

Which parent has physical custody of the dependent child/children (custodial parent)?
☐ Mother ☐ Father

Custodial Parent's address: _____

_____

Custodial Parent's telephone number: _____

Please sign, date, and submit this form to the Fund Office as soon as possible. Thank you.

_____ _____
Signature of Insured Date