EMPLOYERS' AND LABORERS LOCALS 100 & 397 HEALTH & WELFARE FUND

4940 WASHINGTON BLVD. • ST. LOUIS, MO 63108 • (314) 367-6555

COORDINATION OF BENEFITS (COB) QUESTIONNAIRE

Please complete and return this form to Ekon Benefits at the address above.
Failure to complete and return this form will result in denial of claims

SECTION I – General Information

Member's Name (Please print or type)	**Member's ID #** (from insurance card)	**Member's Date of Birth** / /
Address (Number, Street, City, State, Zip)		**Home Phone Number**

Is your Spouse employed? ☐ Yes ☐No **If Yes, does your Spouse's employer offer group health insurance** ☐ Yes ☐No

Are there any family members covered under another medical Plan?

☐ Yes (Go to SECTION II, if Medicare go to SECTION III) ☐ No (Go to SECTION IV)

SECTION II – Other Health Insurance

Name of Other Health Insurance:	**Other Health Insurance is:** (check one) ☐Group Health Plan ☐Individual Policy ☐Medicaid	**Effective Date:** / /	**Term Date** (if applicable): / /
Address of Other Health Insurance (Number, Street, City, State, Zip):			**Phone Number:** ( ) --
Name of Policyholder:	**Policyholder ID Number:**	**Policyholder Phone Number:** ( ) --	

Does this health plan have prescription drug coverage? ☐Yes ☐No

Is your Prescription ID the same as listed above for your Other Medical Coverage?
☐Yes ☐No (RX ID# _____ Name of Other Prescription Carrier _____

List the Names of those with other coverage (self, spouse and children): **Name**	**Gender**	**Date of Birth**	**Other Coverage**	**For children only: Is this child from a previous marriage or relationship:**	**Name of person with physical custody:**	**If a court order/decree exists for dependents, list the person who is ordered to carry the primary medical coverage:**
1.	F/M	/ /	☐Yes ☐No	☐Yes ☐No		
2.	F/M	/ /	☐Yes ☐No	☐Yes ☐No		
3.	F/M	/ /	☐Yes ☐No	☐Yes ☐No		
4.	F/M	/ /	☐Yes ☐No	☐Yes ☐No		
5.	F/M	/ /	☐Yes ☐No	☐Yes ☐No		
6.	F/M	/ /	☐Yes ☐No	☐Yes ☐No		
Comments:						

SECTION III – Medicare

Name	**Medicare ID/HICN#**	**Part A Eff Date**	**Part B Eff Date**	**Part C Eff Date**	**Part D Eff Date**
1.		/ /	/ /	/ /	/ /
2.		/ /	/ /	/ /	/ /

Member 1 (above) Medicare Eligible due to:
☐Age ☐End Stage Renal Disease (Kidney Dialysis)
☐Disability Date Dialysis Started (mm/dd/yy): _____
☐ALS (Lou Gehrig's Disease If Self Dialysis, Date Started (mm/dd/yy): _____
If Kidney Transplant, Date (mm/yy): _____

Retired: ☐Yes ☐No
Retirement Date: / /

Member 2 (above) Medicare Eligible due to:
☐Age ☐End Stage Renal Disease (Kidney Dialysis)
☐Disability Date Dialysis Started (mm/dd/yy): _____
☐ALS (Lou Gehrig's Disease If Self Dialysis, Date Started (mm/dd/yy): _____
If Kidney Transplant, Date (mm/yy): _____

Retired: ☐Yes ☐No
Retirement Date: / /

SECTION IV – Verification

Any person who knowingly and with intent to defraud any insurance company or other person files and application for insurance or statement of claim containing any materially false information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

I hereby certify that the above information is correct to the best of my knowledge.

Member Name_____ Date: _____