Dependent Declaration of Health Coverage

Dear Member,

If you have a dependent that is age 19 or older, this form must be completed by your dependent.

The purpose of this form is to obtain coordination of benefits information so we may determine if our Plan is the primary or secondary payor for your dependent(s) age 19 and older.

If your dependent who is age 19 or older is employed and has other group health coverage, or if your dependent is married and his or her spouse has other group health coverage, that plan would be the primary payor and this plan would be the secondary payor.

Failure to complete this form and make a complete disclosure of other group insurance will result in delay of payment of claims. Any overpayment by our office must be reimbursed.

I trust this is of assistance to you and clarifies the position of the Fund on coordination of benefits. Should you have any questions regarding this matter please feel free to contact our office at 515-243-3246 or in Iowa 1-866-894-4500.

Sincerely,

Jama Barbour  
Fund Administrator
PLUMBERS & STEAMFITTERS LOCAL UNION NO. 33
HEALTH AND WELFARE FUND
DECLARATION OF DEPENDENT HEALTH COVERAGE
(To avoid any interruption in the processing of your claims, please complete the form and return to the Fund Office)

Member Name: ______________________________ Member's S.S. No.: ______________________
Dependent Name: ____________________________ Dependent's S.S. No.: ______________________
Dependent Address: __________________________ Dependent Phone Number __________________
City/State/Zip: ______________________________

1) I am a dependent, age 19 and older and I am (check one):
   ____ single       ____ married
   AND I am:
   ____ not employed and or a college student     ____ employed full-time

2) I am employed by:
   Employer's Name: ___________________________
   Address: __________________________________
   H.R. Contact Person: ________________________
   Phone Number: ______________________________

3) Information about my Insurance Options through my employer or spouse (check one):
   ____ I am currently covered by my employer’s health insurance and or my spouse’s health
   insurance.
   Name of health plan or insurance company: ___________________________
   Identification/Policy Number: ___________________________ Effective Date of Coverage:
   Policy holder name: ___________________________ Policy holder phone: ______________________
   Coverage includes (check all that apply):
   ____Medical   ____Dental   ____Rx Drugs   ____Vision
   ____ I am eligible for group health coverage through my employer, but have declined
   coverage because ____________________________________________.

(Use this area to provide additional information and or explanations)__________________________________

I declare that the information is true and correct to the best of my knowledge, information and belief. I understand
that the Fund reserves the right to suspend or terminate my health coverage if it concludes that I have provided false or
misleading information in this Declaration. I understand that I am eligible for coverage until age 26. I also understand
that if I have other health coverage through employment or my spouse, that coverage will be the primary insurance
plan. The Fund will only consider claims for payment that have first been submitted to my primary health insurance
carrier. Finally, I understand if I should change employment, get married or have any other event that may cause my
eligibility for health coverage to change, I am required to notify the Fund Office and complete an updated Declaration of
Dependent Health Coverage.

Date __________________________
Dependent Signature ______________________

Fund Office use only.

Other info needed __________
Follow up date and info requested __________________

Processing of your claims may be delayed until this information is provided. Therefore, please return this completed
to the Fund Office promptly.