Jama Barbour
Chief Operating Officer
jbarbour@ualocal33.org

Health and Welfare Fund
2501 Bell Avenue
Des Moines, Iowa 50321-1118

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,

Jamie Smith
Jamie Smith
Fund Office Supervisor

GCC/IBT

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 ____
City/State/Zip__________________________ Dependent Phone Number ___________

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 part-time ___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 ____.

___ My employer doesn't offer group health coverage

(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 form to the Fund Office promptly.