Jama Barbour
Chief Operating Officer
jbarbour@ualocal33.org

PLUMBERS AND STEAMFITTERS
LOCAL UNION 33
HEALTH & WELFARE FUND

BUILDING UNION IS GOOD BUSINESS

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 make a complete disclosure of other group insurance will result in a delay of claim payment. In addition, any overpayment made by the Plan resulting from inaccurate information being given on this form 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 Kooyman

Jamie Kooyman
Fund Office Supervisor

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: _____ Last 4 of Member's SSN: _____

Dependent Name: _____ Last 4 of Dependent's SSN: _____

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 __FSA, HSA, Flex Acct.

___ 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) _____
_____

Under penalties of perjury, 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.