



Mo-Kan Sheet Metal Workers Welfare Fund

P.O. Box 300019
 Kansas City, MO 64130-0019
Coordination of Benefits Form - 2008

Phone 816-531-0334
 Fax 816-753-7252
 www.mokansheetmetal.org

Your insurance with Mo-Kan Sheet Metal Workers Welfare Fund contains a Coordination of Benefits provision. Processing of claims submitted under your contract depends upon your response. **Please respond to this questionnaire within 14 days.**

Section #1 - Information about You

Member's Name: _____ Soc. Sec. # or Mo-Kan #: _____
 (last) (first) (middle)

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone Number: _____

Section #2 - Information about Your Spouse

Name (first, middle, last): _____ Date of Birth: _____ Social Security Number: _____

Is your spouse employed? No Yes (If yes, complete employer information below.)

Employer: _____ Employer's Telephone Number: _____

Employer's Street Address: _____ City: _____ State: _____ Zip: _____

Section #3 - Other Insurance

Besides being covered by Mo-Kan Sheet Metal Workers Welfare Fund, are you, your spouse or any other family member currently covered by any other plan (including group insurance, prescription drug, dental, vision, student, sports policies or Medicare)?

No (If "No" complete Section 5 below) Yes (If "YES" complete Sections 4 and 5 below)

Section #4 - Other Insurance Information

Please indicate below the type of other insurance coverage you have by marking "YES" or "NO." If you answer "YES" please complete the area to the right of the box.

Type of Coverage:	Insurance Company or Carrier Name and Phone Number:	Policy Holder's Name and I.D. Number:	Effective Date and Termination Dates:	Who is Covered?
Medical <input type="checkbox"/> No <input type="checkbox"/> Yes	Carrier: Phone:	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Pres. Drug <input type="checkbox"/> No <input type="checkbox"/> Yes	Carrier: Phone:	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Dental <input type="checkbox"/> No <input type="checkbox"/> Yes	Carrier: Phone:	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children
Vision <input type="checkbox"/> No <input type="checkbox"/> Yes	Carrier: Phone:	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children
<input type="checkbox"/> Medicare <input type="checkbox"/> Medicare	Carrier: Phone:	Policy Holder's Name: Policy I.D. #:	Effect. Date: Term. Date:	<input type="checkbox"/> You <input type="checkbox"/> Spouse <input type="checkbox"/> Children

Section #5. Sign and Date – Return Form to the Fund Office

X _____
 Member's Signature Date

Please return the form in the enclosed envelope or return to the address at the top of this form. It is your responsibility to inform the Fund Office of any changes which occur during the calendar year. Thank you. If you would like additional copies of this form you can print a copy at www.mokansheetmetal.org.