U.A. Plumbers Local Union #68
Health & Welfare Fund

www.plu68benefitfunds.com
P.O. Box 8726 · Houston, TX 77249
Phone (713) 869-2592 · 800-833-2980 · Fax (713) 862-4877
Email: benefits@plu68.com

COORDINATION OF BENEFIT FORM

Due to the HIPAA Privacy Notice our office can no longer verify primary insurance information on your spouse. In order to process any billings for family members that have additional insurance coverage the Fund needs the following information. Please complete and return this form before your current COB statement expires to avoid delay in processing claims.

This section must be completed by Participant.	
Your Name	Last 4Your SSN
Your Mailing Address	City, St Zip
Your Email Address	Your Phone No.
Your Signature	Date

Insured Spouse section. If other coverage has termed, please provide a HIPAA termination letter.	
Insured Spouses Name Insured Spouses SSN	Does carrier use the birthday rule or gender rule to determine liability?
Is there an open enrollment period? Yes No If so, when?	Does employee have any of the following benefits? Medical Dental Optical Prescription Drug
Name of Medical Insurance Carrier	Group Policy Number Is coverage for self or dependent? Self Dependent
Effective Date of Coverage Termination Date of Coverage	List dependents covered if applicable
Name of Dental Insurance Carrier if applicable	Group Policy Number Is coverage for self or dependent? Self Dependent
Effective Date of Coverage Termination Date of Coverage	List dependents covered if applicable
Name of Optical Insurance Carrier if applicable	Group Policy Number Is coverage for self or dependent? Self Dependent
Effective Date of Coverage Termination Date of Coverage	List dependents covered if applicable
Name of Prescription Drug Insurance Carrier if applicable	Group Policy Number Is coverage for self or dependent? Self Dependent
Effective Date of Coverage Termination Date of Coverage	List dependents covered if applicable
Name of person competing this form (printed) Date	Signature of person completing this form