Roofers' Unions Welfare Trust Fund

Fund Office
2021 Swift Drive, Suite B
Oak Brook, IL 60523

Phone: (847) 827-1029
Fax: (847) 827-6358

COORDINATION OF BENEFITS (COB) INFORMATION FORM

The Roofers' Unions Welfare Trust Plan contains a coordination of benefits provision, which requires you to furnish the Fund Office with information regarding any other health, dental or vision coverage you or your covered dependents may have. **PAYMENT OF FUTURE CLAIMS FROM THE PLAN MAY BE DELAYED IF THE FUND OFFICE DOES NOT RECEIVE THIS INFORMATION WITHIN 30 DAYS FROM DATE OF LETTER. FAXES ARE NOT ACCEPTABLE.**

Roofer's/Employee's Name: _____ Social Security No:_____

Address: _____

City: _____State: _____ Zip Code: _____

Telephone Number: (_____)_____

Single_____Married_____Divorced_____Widowed_____

Are you or any of your dependents covered under **ANOTHER** health, dental or vision plan (through an employer, school, Medicare or government)?

Yes _____ Please attach a copy (ies) of the front and back of your insurance card. If you do not attach a copy (ies) of your insurance card, please complete the reverse side of this form.

No _____ Please sign, date and return form.

Is your spouse or the natural parent of your child (ren) employed? Yes_____ No_____

Employer Name: _____

Address: _____

Telephone Number: (_____)_____

I (We) certify that the information provided is true and correct. I (We) also authorize the Roofers' Unions Welfare Trust Fund to obtain from any employee benefit plan, trust fund, employer, or insurance carrier, all eligibility, benefit coverage and claims payment information to which I or any of my dependents may be entitled to and for these organizations to release to the Roofers' Unions Welfare Trust Fund any such information, in order for the Roofers' Unions Welfare Trust Fund to process claims. This authorization will expire two years from the date this form is signed. I (We) understand that this authorization may be revoked by written request to the Fund Office. I (We) understand that information disclosed may no longer be protected by the Federal Privacy Law.

Date _____ Roofer's/Employee's Signature _____

Date _____ Spouse's Signature _____

Date _____ Dependent Signature ***(age 18 and over)*** **_____**

Por favor, si usted no entiende como completar esta forma, contacte la Oficina de Fondo al (847)827-1029

(over)

Name of Policyholder _____ Relationship_____

Medical

Name of Carrier: _____

Group/Policy No: _____

Telephone Number: (_____) _____

Effective Date: _____Coverage: Single _____Family _____

Dental

Name of Carrier: _____

Group/Policy No: _____

Telephone Number: (_____) _____

Effective Date: _____Coverage: Single _____Family _____

Vision

Name of Carrier: _____

Group/Policy No: _____

Telephone Number: (_____) _____

Effective Date: _____Coverage: Single _____Family _____