MASSACHUSETTS LABORERS' HEALTH & WELFARE FUND
P.O. Box 1501, 1400 District Avenue, Suite 200
Burlington, Massachusetts 01803
Telephone (781) 272-1000 • Toll Free (800) 342-3792 • Fax (781) 238-0703 • claims@mlbf.org

Coordination of Benefits Questionnaire

Member Name: MLBF ID:_____
Address:
City, State:

The Massachusetts Laborers' Health & Welfare Fund contains a coordination of benefits provision. We depend upon your help for us to process your claims correctly. We appreciate your prompt and accurate reply. If any of the information below changes, please contact the Fund office immediately.

Please complete this Form and return to the Health Fund as soon as possible to avoid nonpayment of medical claims for your dependents.

Are you or any member of your family covered by another health care policy, including Medicare?
[ ] YES, If yes, please complete all of the applicable fields below
[ ] NO, If no please sign and date the bottom of this form

Section A

- **Please attach a copy of your other insurance card**

Other Insurance Name:	Member ID#
Other Insurance Address and phone number:	
Policy Holder's Name:	Effective Date:

Type of coverage: [ ] Single [ ] Family [ ] Single + One
List dependents covered on other plan:

Name:	Date of Birth:	Relationship to Insured:

Section B if this does not apply, skip to Section C

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Medicare Information:

Are you or any of your dependents eligible for Medicare Coverage? YES OR NO Name of person with Medicare:_____

Medicare Number, including alpha character:_____
Part A Effective Date: __/__/_____ Part B Effective Date: __/__/____

Entitlement Reason: Age Disability End Stage Renal Disease (ESRD)*
*If reason is ESRD, please provide the 1st date of dialysis: _/___/ _____

Section C If this does not apply, please sign, date, and submit form

Court Order Information:

Are you divorced or legally separated from the other policy holder in section A? [ ] YES [ ] NO

Is there a court order specifying a person to maintain health coverage for your dependents? (If yes, please provide a copy of the court order.)[ ]YES OR [ ]NO

If yes, who is the person listed to maintain coverage: _____

Which parent has physical custody of the dependent child/children (custodial parent)?

[ ] Mother [ ] Father

Father Custodial Parent's address: _____
_____

Custodial Parent's telephone number:_____

Please sign, date, and submit this form to the Fund Office as soon as possible. Thank you.

_____ _____
Signature of Insured Date