UFCW Local 1459 and Contributing Employers Health & Welfare Fund

33 Eastland Street * Springfield, MA 01109-2348 * (413) 733-0177 or Toll Free 1-800-634-2700

MEDICARE AND OTHER COVERAGE INFORMATION FORM

Type or print clearly in blue or black ink.

INSTRUCTIONS: Fully complete all sections of this form even if you or your eligible dependents are not currently covered under Medicare or another health plan besides the UFCW Local 1459 Health & Welfare Fund. Return this form and any supporting documentation to the Fund Office.

Section 1: PERSONAL PROFILE

NAME (LAST) (FIRST) (MI)			SOCIAL SECURITY NUMBER	BIRTH DATE (MM/DD/YYYY)
STREET ADDRESS				HOME TELEPHONE
CITY	ST	ZIP		WORK TELEPHONE
MARITAL STATUS (CHECK ONE) ❑SINGLE ❑MARRIED ❑DIVORCED ❑SEPARATED ❑WIDOWED		SEX ❑M ❑F	E-MAIL ADDRESS	

Section 2: MEDICARE INFORMATION

a. Are you, your eligible spouse or your eligible dependent child(ren) covered under Medicare **Part A or Part B**?
❑Yes ❑No If "No", skip to Section 3.
If "Yes", please complete the following section for each Medicare enrollee:

Medicare Enrollee #1

NAME (LAST) (FIRST)	BIRTH DATE (MM/DD/YYYY)	RELATIONSHIP TO YOU (CHECK ONE) ❑SELF ❑SPOUSE ❑SON ❑DAUGHTER ❑OTHER __________
MEDICARE HEALTH INSURANCE CLAIM NUMBER (HICN)		SOCIAL SECURITY NUMBER
TYPE(S) OF MEDICARE COVERAGE (CHECK ALL THAT APPLY) ❑ PART A (HOSPITAL) EFFECTIVE DATE: ______________ ❑ PART B (MEDICAL) EFFECTIVE DATE: ______________	REASON(S) FOR MEDICARE (CHECK ALL THAT APPLY) ❑ AGE 65 OR OLDER ❑ DISABILITY (IF YES, WHAT IS YOUR DISABILITY?) ______________ ❑ END STAGE RENAL DISEASE (ESRD) DATE DIALYSIS BEGAN: ______________	

Medicare Enrollee #2

NAME (LAST) (FIRST)	BIRTH DATE (MM/DD/YYYY)	RELATIONSHIP TO YOU (CHECK ONE) ❑SELF ❑SPOUSE ❑SON ❑DAUGHTER ❑OTHER __________
MEDICARE HEALTH INSURANCE CLAIM NUMBER (HICN)		SOCIAL SECURITY NUMBER
TYPE(S) OF MEDICARE COVERAGE (CHECK ALL THAT APPLY) ❑ PART A (HOSPITAL) EFFECTIVE DATE: ______________ ❑ PART B (MEDICAL) EFFECTIVE DATE: ______________	REASON(S) FOR MEDICARE (CHECK ALL THAT APPLY) ❑ AGE 65 OR OLDER ❑ DISABILITY (IF YES, WHAT IS YOUR DISABILITY?) ______________ ❑ END STAGE RENAL DISEASE (ESRD) DATE DIALYSIS BEGAN: ______________	

If additional space is needed, please attach separate sheet.

Section 3: DEPENDENT CHILDREN COVERED UNDER DIVORCE DECREE OR COURT ORDER

a. Is your eligible dependent child(ren) covered under a divorce decree or court order? ❑ Yes ❑ No
If "No", skip to Section 4. If "Yes", list the name of the child(ren):______________________
and the name of the party that has physical custody of the dependent child(ren)? ______________________
Include a copy of the court order, QMSCO, or divorce decree with this form (unless previously submitted).

b. Does the divorce decree or court order stipulate which party is responsible for maintaining health coverage on the dependent child(ren)? ❑ Yes ❑ No If "Yes", list the name of the party:______________________
and list the other health coverage in Section 4.

FOR FUND OFFICE USE ONLY:
Plan _______________ Eff_____________________
Claims_______________ ___________ COBP Y N
Elig _______________ ___________ LP Ltr Y N

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MEDICARE AND OTHER COVERAGE INFORMATION FORM

Section 4: OTHER HEALTH COVERAGE INFORMATION
(This does not include coverage through Medicare or the UFCW Local 1459 Health & Welfare Fund)

a. If you are married, is your spouse employed? ❑Yes ❑No ❑Not Married
If “Yes”, does your spouse’s employer offer family health coverage? ❑Yes ❑No
b. Did your spouse elect coverage? ❑Yes ❑No If “No”, explain why: ______________________________
c. Are you, your eligible spouse or your eligible dependent children covered under another health plan?
❑ Yes ❑ No If “No”, skip to Section 5. If “Yes”, please complete the following section for each health plan:

Other Health Coverage #1

NAME OF PERSON WHO IS THE POLICYHOLDER OF OTHER COVERAGE	POLICYHOLDER’S BIRTH DATE (MM/DD/YYYY)
POLICYHOLDER’S RELATIONSHIP TO YOU ❑ SELF ❑ SPOUSE ❑ EX-SPOUSE ❑ PARENT ❑ CHILD ❑OTHER ______________	
NAME OF OTHER INSURANCE COMPANY OR PLAN	NAME OF POLICYHOLDER’S EMPLOYER
ADDRESS OF OTHER INSURANCE COMPANY OR PLAN *(STREET, CITY, STATE, AND ZIP)*	ADDRESS OF POLICYHOLDER’S EMPLOYER *(STREET, CITY, STATE, AND ZIP)*
IDENTIFICATION NUMBER	EFFECTIVE DATE OF POLICY
POLICY NUMBER	TERMINATION DATE OF POLICY
TYPE OF INSURANCE ❑ INDIVIDUAL ❑ FAMILY	LIST THE NAMES OF THE FAMILY MEMBER(S) COVERED UNDER THIS POLICY ❑ SELF ❑ SPOUSE ______________ ❑ CHILD(REN)______________ ❑ EX-SPOUSE ______________ ❑ PARENT ______________ ❑OTHER ______________
COVERAGE TYPES (CHECK ALL THAT APPLY) ❑ HOSPITAL ❑ MAJOR MEDICAL ❑ DENTAL ❑ VISION ❑ PRESCRIPTION	

Other Health Coverage #2

NAME OF PERSON WHO IS THE POLICYHOLDER OF OTHER COVERAGE	POLICYHOLDER’S BIRTH DATE (MM/DD/YYYY)
POLICYHOLDER’S RELATIONSHIP TO YOU ❑ SELF ❑ SPOUSE ❑ EX-SPOUSE ❑ PARENT ❑ CHILD ❑OTHER ______________	
NAME OF OTHER INSURANCE COMPANY OR PLAN	NAME OF POLICYHOLDER’S EMPLOYER
ADDRESS OF OTHER INSURANCE COMPANY OR PLAN *(STREET, CITY, STATE, AND ZIP)*	ADDRESS OF POLICYHOLDER’S EMPLOYER *(STREET, CITY, STATE, AND ZIP)*
IDENTIFICATION NUMBER	EFFECTIVE DATE OF POLICY
POLICY NUMBER	TERMINATION DATE OF POLICY
TYPE OF INSURANCE ❑ INDIVIDUAL ❑ FAMILY	LIST THE NAMES OF THE FAMILY MEMBER(S) COVERED UNDER THIS POLICY ❑ SELF ❑ SPOUSE ______________ ❑ CHILD(REN)______________ ❑ EX-SPOUSE ______________ ❑ PARENT ______________ ❑OTHER ______________
COVERAGE TYPES (CHECK ALL THAT APPLY) ❑ HOSPITAL ❑ MAJOR MEDICAL ❑ DENTAL ❑ VISION ❑ PRESCRIPTION	

If additional space is needed, please attach separate sheet

Section 5: CERTIFICATION and SIGNATURE

I certify that the above information is correct and complete to the best of my knowledge. I understand that I am obligated to provide this information in accordance with my plan. Failure to provide complete and accurate information may result in delay or denial of claim payments. Intentionally providing false information may result in termination of benefits.

EMPLOYEE’S SIGNATURE: ______________________________ **DATE:** ________________