1199 NEW ENGLAND HEALTH CARE WELFARE FUND COORDINATION OF BENEFITS
2025 Plan Year

SECTION 1: PARTICIPANT INFORMATION

Participant Name: Last Name, First Name	**Birth Date:**	**Employment Status** Active ☐ Retired ☐	**If Retired**, Date of Retirement
Member ID or Social Security #		**Home/Cell Phone Number**:	

SECTION 2: OTHER HEALTH INSURANCE INFORMATION

Name of Policy Holder of other insurance: Last Name: / First Name:	**Birth Date:**	**Sex:** Male ☐ Female ☐	**Social Security #**	**Relationship to You** (If not self)

Name of Other Health Insurance Company:	**Policyholder Identification Number:**
Other Health Insurance Company Address:	**Other Health Insurance Company Phone #**

List Family Member(s) with coverage including birth date of each and effective date of coverage(if more space is needed, please list additional members and relationship to you on the back of this form:

Coverage Type: **Group** ☐ **Medical** ☐ Dental ☐ **Vision** ☐ **Drug** ☐

Coverage Effective Date:_____ **Coverage Cancellation Date(If Applicable)**:_____

SECTION 3: MEDICARE COVERAGE INFORMATION

Name of Medicare Participant: Last Name: _____ **First Name:**_____

Medicare #_____**Relationship to you (Leave blank if self)**_____

Effective Date Part A: _____**Effective Date Part B:**_____

Effective Date Part D:_____

Medicare Eligibility Due to:

Age ☐ **Disability** ☐ **End-Stage Renal Disease** ☐ **Initial Dialysis Date**:_____

SECTION 4: SIGNATURE AND DATE

I certify that the information furnished by me on this form is true and correct at this time and agree to inform the 1199 New England Health Care Employees Welfare Fund ("The Fund") of any changes.

Participant Signature: **Today's Date:**