1199SEIU Benefit Funds
Member Eligibility, PO Box 1035 • New York, NY 10108-1035 • Tel: (646) 473-9200 • Outside NYC area codes: (800) 575-7771 • www.1199SEIUBenefits.org

COORDINATION OF BENEFITS FORM FOR SPOUSE COVERAGE

This form is strictly confidential. You must answer all the questions. Please print clearly in blue or black ink.

MEMBER'S INFORMATION

Member's full name _____ Member ID # _____ Benefit Fund: ☐ NBF ☐ GNY ☐ GNY/NJ ☐ LPN

Address _____ City _____ State _____ Zip code _____

Home phone _____ Cell phone _____

Email address _____

SPOUSE'S INFORMATION

Spouse's full name _____ Social Security # _____

Date of birth _____ Sex: ☐ M ☐ F

Cell phone _____

Email address _____

Please indicate in the following sections if your spouse can receive health insurance through another source. Fill out all that apply:

Spouse's Health Plan

1. Is your spouse employed? ☐ No ☐ Yes ☐ Has never been employed _____ If "yes," list last date employed

2. Is your spouse self-employed? ☐ No ☐ Yes _____ If "yes," list profession

3. If "yes" to question 1, does your spouse's employer offer health insurance? ☐ No ☐ Yes

Spouse's Employer Information

Employer's name _____

Employer's address _____ City _____ State _____ Zip code _____

Employer's phone _____ Spouse's job title _____

Please indicate the type of coverage your spouse is offered. Check all that apply: ☐ Medical ☐ Hospital ☐ Prescription ☐ Dental ☐ Vision

Please indicate the type of coverage your spouse is enrolled in. Check all that apply: ☐ Medical ☐ Hospital ☐ Prescription ☐ Dental ☐ Vision

Name of group or individual insurance plan _____ Policy group # _____ Effective date _____

Insurance plan's phone _____ Coverage type (check one): ☐ Individual ☐ Family

4. If your spouse is eligible for an employer-sponsored plan and is **not enrolled in the plan, why is he or she not enrolled?**

_____

_____

_____

Medicare

Does your spouse have Medicare coverage? ☐ No ☐ Yes If "yes," please answer the following questions about your spouse's Medicare coverage:

Is your spouse enrolled in Part A? ☐ No ☐ Yes _____ If "yes," list effective date

Is your spouse enrolled in Part B? ☐ No ☐ Yes _____ If "yes," list effective date

Is your spouse's Medicare coverage based on a disability? ☐ No ☐ Yes _____ Spouse's Medicare claim number

This Coordination of Benefits Form for Spouse Coverage is for Fund use only, and will not be released to any third party except where necessary for the administration and operation of the Fund, or where otherwise required by law. The foregoing statements are, to the best of my knowledge, true and complete. I authorize any hospital, physician or other healthcare provider to release to the Fund and its agents any records of information, without restriction, concerning me or any member of my family receiving benefits from the Fund. Unless I revoke it in writing, this authorization will be effective as long as I am a participant in the Fund. A photocopy of this authorization shall be as valid as the original. I understand that under the terms of the plan (Summary Plan Description, SPD), the Fund has a right to be reimbursed for any money it pays on my behalf for expenses caused by a third party. If the Fund pays any such claims, it will have a lien on payments I receive from, or on behalf of, the third party, and I agree to pay back the Fund for any payments it has made. This agreement will be effective for all benefits incurred while I am a participant in the Fund, even if I receive payments from, or on behalf of, a third party when I am no longer a participant.

I certify that the foregoing is true and correct.

X _____

Member's signature **Date**

Failure to respond will create a gap in coverage for your spouse.