1199SEIU Benefit Funds

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

Coordination of Benefits Form for Young Adult Coverage

Instructions: Complete a separate Coordination of Benefits Form for Young Adult Coverage for each dependent child from age 19 up to age 26 for whom you are requesting Benefit Fund coverage. Please print clearly in blue or black ink, or complete online.

Please complete this form and mail to:
1199SEIU Benefit Funds, Member Eligibility, PO Box 1035, New York, NY 10108-1035

MEMBER'S INFORMATION

MEMBER'S FULL NAME (FIRST AND LAST) _____ MEMBER ID # _____

Please indicate the benefit fund(s) you are enrolled in ***(check all that apply):*** ☐NBF ☐GNY ☐Home Care ☐GNY-NJ ☐NBF Rochester ☐LPN Welfare

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

EMAIL ADDRESS _____

YOUNG ADULT'S INFORMATION

DEPENDENT'S FULL NAME (FIRST AND LAST) _____ SOCIAL SECURITY # (XXX-XX-XXXX) _____ SEX: ☐Male ☐Female

ADDRESS (IF DIFFERENT FROM MEMBER) _____ CITY _____ STATE _____ ZIP CODE _____

HOME PHONE NUMBER _____ CELL PHONE NUMBER _____

EMAIL ADDRESS _____

In the following sections, please indicate if your young adult dependent can receive health insurance through another source. Fill out all that apply.

1. OTHER PARENT'S HEALTH PLAN

Does your young adult dependent receive health insurance through his or her other parent's employer? ☐No ☐Yes

If "Yes," please provide the following information:

PARENT'S FULL NAME (FIRST AND LAST) _____ PARENT'S DATE OF BIRTH (MM/DD/YYYY) _____

NAME OF EMPLOYER _____

EMPLOYER'S ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

Please indicate the type of coverage ***(check all that apply)***: ☐Medical ☐Hospital ☐Prescription ☐Dental ☐Vision

PLEASE CONTINUE ON REVERSE SIDE

NAME OF INSURANCE PLAN | EFFECTIVE DATE OF COVERAGE (MM/DD/YYYY)

POLICY/GROUP # | INSURANCE PLAN PHONE NUMBER

2. EMPLOYER HEALTH PLAN

Does your young adult dependent receive health insurance through his or her employer? ☐No ☐Yes

If "Yes," please provide the following information:

NAME OF EMPLOYER

EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE

Please indicate the type of coverage ***(check all that apply):*** ☐Medical ☐Hospital ☐Prescription ☐Dental ☐Vision

NAME OF INSURANCE PLAN | EFFECTIVE DATE OF COVERAGE (MM/DD/YYYY)

POLICY/GROUP # | INSURANCE PLAN PHONE NUMBER

3. SPOUSAL HEALTH PLAN

Does your young adult dependent receive health insurance through his or her spouse's employer? ☐No ☐Yes

If "Yes," please provide the following information:

SPOUSE'S FULL NAME (FIRST AND LAST) | SPOUSE'S DATE OF BIRTH (MM/DD/YYYY)

NAME OF EMPLOYER

EMPLOYER'S ADDRESS | CITY | STATE | ZIP CODE

Please indicate the type of coverage ***(check all that apply):*** ☐Medical ☐Hospital ☐Prescription ☐Dental ☐Vision

NAME OF INSURANCE PLAN | EFFECTIVE DATE OF COVERAGE (MM/DD/YYYY)

POLICY/GROUP # | INSURANCE PLAN PHONE NUMBER

READ BELOW. PRINT OUT THE COMPLETED FORM, THEN SIGN AND DATE IT.
THE FORM CANNOT BE PROCESSED WITHOUT THE MEMBER'S AND THE YOUNG ADULT'S SIGNATURE.
FAILURE TO RESPOND WILL CREATE A GAP IN COVERAGE FOR YOUR YOUNG ADULT DEPENDENT.

This coordination of benefits form is for the 1199SEIU Benefit Funds' use only, and will not be released to any third party except where necessary for the administration and operation of the Benefit Funds, 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 Benefit Funds and its agents any records of information, without restriction, concerning me or any member of my family receiving benefits from the Benefit Funds. Unless I revoke it in writing, this authorization will be effective as long as I am a participant in the Benefit Funds. I understand that under the terms of the Plan (Section I.G of the Summary Plan Description), the Benefit Funds has the right to be reimbursed for any money it pays on my behalf for expenses caused by a third party. If the Benefit Funds pay 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 Benefit Funds for any payments it has made. This agreement will be effective for all benefits incurred while I am a participant in the Benefit Funds, even if I receive payments from, or on behalf of, a third party when I am no longer a participant. If I provided my email address on this form, I consent to receiving Benefit Funds information by email, and I understand that communications over the Internet may not be secure.

X _____

MEMBER'S SIGNATURE **(REQUIRED)** | DATE (MM/DD/YYYY) **(REQUIRED)**

X _____

YOUNG ADULT'S SIGNATURE **(REQUIRED)** | DATE (MM/DD/YYYY) **(REQUIRED)**