INDIANA LABORERS WELFARE FUND
P.O. BOX 1587 TERRE HAUTE, INDIANA 47808-1587
Telephone (812) 238-2551 Toll Free 1-800-962-3158
Fax (812) 238-2553 www.indianalaborers.org

COORDINATION OF BENEFITS (COB) and DEPENDENT VERIFICATION FORM

This Dependent Verification and COB Form is required to be completed annually. **Failure to complete and return will result in non-payment of claims.**

DEPENDENT NAME RELATION DOB PHONE NUMBER

1. Should any of the above listed Dependents be removed due to divorce or court order?

   ☐ Yes ☐ No

   If you answered "Yes," please list the Dependents to be removed and submit a copy of the court order and/or divorce decree with any incorporated settlement agreement:

   _____

2. Should any Dependents be included in your health benefit plan who are ***NOT*** listed above?

   ☐ Yes ☐ No

   If you answered "Yes," please contact the Fund Office to request a Dependent Enrollment Form.

COMPLETE BOTH SIDES OF FORM

Participant:
ID#:

3. Are you or any of the above listed Dependents covered by any other medical/dental/ prescription or vision plan?

   ☐ Yes ☐ No

   If you answered "Yes," you will need to submit a copy of the front and back of all other carriers' benefit card(s).

4. Do you or any or your dependents have medical or prescription benefits or services under any Medicare program?

   ☐ Yes ☐ No

   If you answered "Yes," you will need to submit a copy of the Medicare card(s) for yourself and any dependent that is not already on file. If Medicare entitlement is due to disability, you will also need to submit a copy of the Medicare award letter that indicates the reason for Medicare entitlement.

I hereby certify that all information provided is correct. I understand that if this information changes, it is my responsibility to notify the Indiana Laborers Welfare Fund Office immediately. I also understand that I will be required to reimburse the Indiana Laborers Welfare Fund for any payments made as a result of my failure to notify of a change in the information on this Coordination of Benefits and Dependent Verification Form.

_____ _____
Participant Signature Date

_____ _____
Spouse Signature Date