PRINT

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

Participant:
ID#:

DEPENDENT VERIFICATION
and
COORDINATION OF BENEFITS (COB) REQUEST FORM

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

DEPENDENT NAME	RELATION	DOB	EMPLOYED
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

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 _____

2. Should any Dependents be included in your health benefit plan who are *not* listed above?
   ☐ Yes ☐ No

   If you answered "Yes" you must complete the enclosed Enrollment Form.

COMPLETE BOTH SIDES OF FORM

Officers-Board of Trustees

Francis J. Gantner
Chairman

David A. Frye
Secretary-Treasurer

Somer Taylor
Administrative Manager

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 all other carriers' benefit cards.

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 a 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 Dependent Verification and Coordination of Benefits Form.

_____ _____

Participant Signature Date

_____ _____

Spouse Signature Date