UNITED FOOD AND COMMERCIAL WORKERS UNION
HEALTH AND WELFARE FUND
27 Roland Avenue, Suite 100, Mount Laurel, NJ 08054
(856) 793-2500 (800) 228-7484 Fax (856) 793-3100

COORDINATION OF BENEFITS (COB) FORM FOR ADULT CHILDREN (to Age 26)

Employee (Participant) Information

Employee (Participant) Last Name	First Name/Middle Initial	Sex	Date of Birth	Social Security Number
		□ M □ F	/ /	
Employee (Participant) Address	City / State / Zip			Phone Number

Name of Employer	□ Full time □ Part time	Marital Status: □ Single □Married □Separated □ Divorced	Local Union Number	Date of Hire / /

Adult Child Information NOTE: If you have more than one eligible adult child, please make copies of this form or call the Fund Office at 1-800-228-7484

Last Name First Name Middle Initial	Sex	Date of Birth	Social Security Number
	□ M □ F	/ /	

Does the **adult child** listed above have coverage **available** through any Benefit Plan other than this Fund? **__YES __NO**
Does the **adult child** listed above have coverage through any Benefit Plan other than this Fund? **__YES __NO; If yes, coverage is through: adult child's** employment ____, a parent ____, **adult child's** spouse ____, Medicaid ____.

Indicate below the type(s) of benefit coverage available and provide the requested insurance company information.

□ Hospitalization: Medical/Surgery	□ Major Medical	□ Drug Card or Prescription Benefit	□ Dental	□ Vision

Name of Other Insurance Company	Is this an HMO? □Yes □ No

Effective Date of Other Insurance	Address of Other Insurance	Phone Number

Signature and Authorization to Release Information

The Benefits available are subject to the accuracy of the information provided. I agree to be responsible to reimburse the Fund for payment made by the Fund when there are other benefits available. I also agree to the release of information from any employer, insurance company, heath care provider or organization regarding coverage.

Employee/Participant Signature:_____	Date _____
Adult Child Signature: _____	Date _____