**UNITED FOOD AND COMMERCIAL WORKERS UNION**
**TRI-STATE 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<br>☐ M ☐ F | Date of Birth<br>/ / | Social Security Number |
| Employee (Participant) Address | City / State / Zip | | | Phone Number |

| Name of Employer | ☐ Full time<br>☐ Part time | Marital Status: ☐ Single<br>☐Married ☐Separated ☐ Divorced | Local Union Number | Date of Hire<br>/ / |
|---|---|---|---|---|

**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<br>☐ M ☐ F | Date of Birth<br>/ / | Social Security Number |
|---|---|---|---|---|---|

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?<br>☐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 ______________