T TEAMSTERS
B BENEFIT
T TRUST

Post Office Box 5820
Fremont, California 94537

39420 Liberty Street, Suite 260
Fremont, California 94538

www.tbt.fund.org

Telephone (510) 796-4676 • (800) 533-0119 • FAX (510) 795-0738

COORDINATION OF BENEFITS (COB) QUESTIONNAIRE

This COB Questionnaire must be re-submitted to this office every 12 months. Please complete and fax to 510-795-0738 or mail to: Teamsters Benefit Trust, Post Office Box 5820, Fremont, CA 94537 – Attention: Claims Department

NOTE: Benefits cannot be determined and claims <u>WILL NOT</u> be paid until this information is received. If you have questions, please call 800-533-0119 and ask for the Claims Customer Service Unit.

PLEASE PRINT CLEARLY.

TBT Employee's Name: _____ SS#:_____

Spouse's Name: _____ SS#:_____

Dependent Child (age 19 & over) Name: _____ Employed: Yes ☐ No ☐

If yes, is group health insurance offered? Yes ☐ No ☐

1. Policyholder's name: _____ 3. Policyholder's SS#: _____

2. Name or Other Insurance: _____ 4. Effective Date of Policy: _____

In addition to your Teamsters Benefit Trust (TBT) coverage, are you, your spouse or dependent children covered by another group health insurance plan <u>or</u> Medicare?

You Yes ☐ No ☐ **Spouse** Yes ☐ No ☐ N/A ☐ **Dependent Children** Yes ☐ No ☐ N/A ☐

If you marked yes, provide the following other group health insurance information, sign the back of this form and submit to the TBT Plan Administration office.

If you marked no, sign the back of this form and submit to the TBT Plan Administration office.

OTHER GROUP HEALTH INSURANCE INFORMATION:

☐ MALE

1. Policyholder's Name: _____ Sex: ☐ FEMALE

2. Policyholder's SS#: _____Date of Birth: _____

3. Name of Other Insurance: _____

4. Is this an Employer Group Health Plan: Yes ☐ No ☐ Name of Employer: _____

5. Effective Date of Policy: _____Cancellation Date (If Applicable):_____

6. Other Insurance Covers: Policyholder Only _____Two Persons _____Family_____

_____ _____
Name Relationship to Policyholder

_____ _____
Name Relationship to Policyholder

(A 4)

7. Services Covered:

a. Medical	Yes ☐	No ☐
b. Eye or Vision Care	Yes ☐	No ☐
c. Dental Coverage	Yes ☐	No ☐
d. Prescription Benefits	Yes ☐	No ☐

8. Do you or any of your dependents have **MEDICARE** coverage?

You: Yes ☐ No ☐ **Spouse:** Yes ☐ No ☐ N/A ☐

If YES, do you have Medicare **Part A & B**? Yes ☐ No ☐

If you have Medicare Part A **only**, were you offered Medicare Part B? Yes ☐ No ☐

If YES to any of the above, please complete the following:

Eligible for MEDICARE as a result of (check one):

☐ AGE ☐ DISABILITY ☐ END STAGE RENAL DISEASE

_____ _____
Name Relationship to TBT Employee

HIC NUMBER _____EFFECTIVE DATE _____

Note: Please submit a copy of your (or your Dependent's) Medicare ID card to the TBT Plan Administration Office.

I certify that all information provided on this form is true and correct.

TBT Employee's Signature _____ Date _____

Print Name _____

Work Phone Number _____

Home Phone Number _____

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