PENSION, HOSPITALIZATION AND BENEFIT PLAN OF THE ELECTRICAL INDUSTRY

COORDINATION OF BENEFITS FORM

Participants of the Pension, Hospitalization, and Benefit Plan of the Electrical Industry ("the Plan") must comply with the Coordination of Benefits ("COB") provision, which requires notifying the Plan of any other group health coverage for you or your eligible dependents.

Please complete the relevant sections of this form, sign it, and return it with a **clear copy of the front and back of your benefit card** by mail or fax to: Hospitalization Department, Joint Industry Board 158-11 Harry Van Arsdale Jr. Avenue. Flushing, NY 11365 Fax**:** 718-591-1107

SECTION 1: PARTICIPANT INFORMATION:

_____

Last Name First Name

_____

PID / Social Security Number Date of Birth

_____

Address

SECTION 2: COORDINATION OF BENEFIT INFORMATION

If your dependent is a participant in another group health plan, please provide information about this coverage below: Please provide a **clear copy of the front and back of your benefit card**

1. Dependent's Name: _____Date of Birth_____

Name of Dependent's health plan: _____

Effective date of coverage: _____

Relation to Participant (check one): ☐ spouse ☐ child

_____

2. Dependent's Name: _____ Date of Birth_____

Name of Dependent's health plan: _____

Effective date of coverage: _____

Relation to Participant (check one): ☐ spouse ☐ child

SECTION 3: PARTICIPANT'S SIGNATURE

Please print and sign your name and date this form.

_____ _____

Sign Name Date

_____

Print Name