LABORERS' BENEFITS • ST. LOUIS

Welfare Coordination of Benefits

2357 59th Street • St. Louis, MO 63110 • www.stllaborers.com
Phone 314-644-2777 • Fax 314-646-4440

The medical coverage with the Greater St. Louis Construction Laborers' Welfare Fund contains a Coordination of Benefits (COB) provision. Claims/services for you and your dependents will be delayed until the COB form has been fully completed, signed by both the member and spouse and returned to the Benefit Office.

Part One - Member Information

Last Name:	First Name:	Middle Initial:
Member ID#:	Date of Birth:	
Mailing Address:	City & State:	Zip Code:
Phone Number:	E-mail Address:	
Marital Status: ☐ Single ☐ Separated ☐ Married ☐ Divorced	Do you have other insurance coverage: ☐ Yes ☐ No	
Effective Date of other insurance coverage: Termination Date of other insurance coverage:	Type of coverage: ☐ Single ☐ Family ☐ Medical ☐ Dental ☐ Vision ☐ Prescription	
Name of Plan:	Phone Number of Plan:	
Are you eligible for Medicare: ☐ Yes ☐ No **Are you receiving a Social Security check? ☐ Yes ☐ No** **Have you been awarded a Social Security Disability: ☐ Yes ☐ No** **If Yes, when:**	Part A Effective Date: Part B Effective Date:	

Part Two - Spouse Information (If applicable)

Last Name:	First Name:	Middle Initial:
Member ID#:	Date of Birth:	
Mailing Address:	City & State:	Zip Code:
Phone Number:	Employer Name:	
Marital Status: ☐ Single ☐ Separated ☐ Married ☐ Divorced	Do you have other insurance coverage: ☐ Yes ☐ No	
Effective Date of other insurance coverage: Termination Date of other insurance coverage:	Type of coverage: ☐ Single ☐ Family ☐ Medical ☐ Dental ☐ Vision ☐ Prescription	
Name of Plan:	Phone Number of Plan:	
Are you eligible for Medicare: ☐ Yes ☐ No **Are you receiving a Social Security check? ☐ Yes ☐ No** **Have you been awarded a Social Security Disability: ☐ Yes ☐ No** **If Yes, when:**	Part A Effective Date: Part B Effective Date:	

Have you had other health insurance coverage in the past two years? ☐ Yes ☐ No

If so, please complete the information below.

Name of Insured:	Dependent Coverage ☐ Yes ☐ No If so, list dependent name(s):
Effective Date of other insurance coverage: Termination Date of other insurance coverage:	Type of coverage: ☐ Single ☐ Family ☐ Medical ☐ Dental ☐ Vision ☐ Prescription
Name of Plan:	Phone Number of Plan:

Part Three – Dependent Under 18 Information (If applicable)

Name:	Member ID#:	Date of Birth:
Do you live with the member: ☐ Yes ☐ No If no, please list your primary address below:		
Do you have other insurance coverage: ☐ Yes ☐ No	Type of coverage: ☐ Single ☐ Family ☐ Medical ☐ Dental ☐ Vision ☐ Prescription	
Name of Plan:	Phone Number of Plan:	

Dependent Under 18 Information (If applicable)

Name:	Member ID#:	Date of Birth:
Do you live with the member: ☐ Yes ☐ No If no, please list your primary address below:		
Do you have other insurance coverage: ☐ Yes ☐ No	Type of coverage: ☐ Single ☐ Family ☐ Medical ☐ Dental ☐ Vision ☐ Prescription	
Name of Plan:	Phone Number of Plan:	

Dependent Under 18 Information (If applicable)

Name:	Member ID#:	Date of Birth:
Do you live with the member: ☐ Yes ☐ No If no, please list your primary address below:		
Do you have other insurance coverage: ☐ Yes ☐ No	Type of coverage: ☐ Single ☐ Family ☐ Medical ☐ Dental ☐ Vision ☐ Prescription	
Name of Plan:	Phone Number of Plan:	

Dependent Under 18 Information (If applicable)

Name:	Member ID#:	Date of Birth:
Do you live with the member: ☐ Yes ☐ No If no, please list your primary address below:		
Do you have other insurance coverage: ☐ Yes ☐ No	Type of coverage: ☐ Single ☐ Family ☐ Medical ☐ Dental ☐ Vision ☐ Prescription	
Name of Plan:	Phone Number of Plan:	

I understand that it is my responsibility to immediately notify the Benefit Office of any changes in the above information. I certify the above statements are true, complete and accurate to the best of my knowledge. I understand if anything is untruthful, it could result in my termination and/or termination of my dependents and recoupment by the plan. I authorize any physician, hospital, employer, insurance company, or other informant to furnish any information necessary to consider claims(s) on dependents and myself listed above. A photocopy of this authorization should be as valid as the original.

Signature of Member: ______________________________ Date: ______________

Signature of Spouse: ______________________________ Date: ______________

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Health Insurance Authorization for Release of Health Information

2357 59th Street ● St. Louis, MO 63110 ● www.stllaborers.com
Phone 314-644-2777 ● Fax 314-646-4440

I understand that the Greater St. Louis Construction Laborers' Welfare Fund Benefit Office, pursuant to new privacy laws, may not generally disclose my health information without my written authorization to my family members or other individuals that I may want to have access to my health information. For this reason, I authorize Greater St. Louis Construction Laborers Welfare Fund to discuss and disclose my health information that is maintained by the Fund to the person(s) that I have named below.

I understand that I have the right to limit the information that the Fund releases under this authorization. For example, I may limit my Authorized Representative's access to information about a particular health care provider or a particular diagnosis/disease. Any such limitations must be described below in writing. I understand that by leaving this section blank, I am creating no limitations on disclosure.

Member Name:	Member ID#:
Authorized Representative Name #1:	Relationship to You:
Authorized Representative Name #2:	Relationship to You:
Do you want your representative(s) to have limits? ☐ Yes ☐ No If yes, be sure to list the limits: ***I authorize the Construction Laborers' Welfare Fund to share my information with the Pension Fund related to my retirement? ☐Yes ☐No*** ***I authorize the Construction Laborers' Benefit Office to share my contribution/eligibility information with my Union Hall? ☐Yes ☐No***	
Member Signature:	Date:

Spouse Name:	Member ID#:
Authorized Representative Name #1:	Relationship to You:
Authorized Representative Name #2:	Relationship to You:
Do you want your representative(s) to have limits? ☐ Yes ☐ No If yes, be sure to list the limits:	
Spouse Signature:	Date:

This authorization to release information to my Authorized Representative will automatically expire upon a lapse of my enrollment in the plan for a period of two consecutive years.

1. You may revoke this Authorization at any time. However, any revocation will not apply to the extent that we have already taken action in reliance upon your Authorization. Your request for revocation must be in writing. We will provide you with a revocation form at your request.
2. We may not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits upon your signing this Authorization.
3. Information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by Federal health information privacy laws.
4. You are entitled to a signed copy of this Authorization.

I have had full opportunity to read and consider the content of this Authorization. I confirm that this authorization is at my request. I understand that, by signing this form, I am confirming my authorization that the health plan may use and/or disclose my personal health information to the person(s) named in Section B.

Be sure to return this form if you would like to authorize an individual(s).