Industry And Local 338
Welfare Fund

911 Ridgebrook Road
Sparks, MD 21152-9451
Telephone No. (855) 412-3797 (toll free)
www.associated-admin.com

Dear Participant:

Coordination of Benefits occurs when you are covered by both the Industry and Local 338 Welfare Fund and another group health plan. Please provide us with the following information to ensure that we have updated information on group health coverage available to you, your spouse and other dependents.

Please list all family members (not including yourself) who should be enrolled as dependents under this Plan:

Dependent's Name	Relationship	Date of Birth	Dependent's Employer, if any, including address and telephone number

Please complete the chart below to determine primary coverage for **Medical**. If no other coverage is *available*, please write, "N/A."

Who is covered? Please list names below.	Name of insurance plan:	Group Number:	Policy Number:	Effective Date:	What type of coverage is provided?
Participant:					
Spouse:					
Child:					
Child:					
Child:					

Please complete the chart below to determine primary coverage for **Prescription Drug**. If no other coverage is *available*, please write, "N/A."

Who is covered? Please list names below.	**Name of insurance plan:**	**Group Number:**	**Policy Number:**	**Effective Date:**	**What type of coverage is provided?**
Participant:					
Spouse:					
Child:					
Child:					
Child:					

Please complete the chart below to determine primary coverage for **Dental**. If no other coverage is *available*, please write, "N/A."

Who is covered? Please list names below.	**Name of insurance plan:**	**Group Number:**	**Policy Number:**	**Effective Date:**	**What type of coverage is provided?**
Participant:					
Spouse:					
Child:					
Child:					
Child:					

Please complete the chart below to determine primary coverage for **Vision**. If no other coverage is *available*, please write, "N/A."

Who is covered? Please list names below.	**Name of insurance plan:**	**Group Number:**	**Policy Number:**	**Effective Date:**	**What type of coverage is provided?**
Participant:					
Spouse:					
Child:					
Child:					
Child:					

If you provided other coverage information in the chart above, please indicate the source of this coverage along with the insurance carrier's address. For example: spouse's employer, another employer of yours, etc.

Source of coverage: _____ **Address:** _____

IMPORTANT: If your spouse was offered or entitled to employer sponsored coverage, was an employee contribution/payment required? If yes, please indicate the amount $_____and frequency (weekly, monthly, other). If the coverage was declined , did your spouse receiving cash or other benefit dollars (such as from a flexible health plan) for doing so? ___Yes ___No

I acknowledge that the above information is true and complete. I am aware that if circumstances change regarding the coverage which is offered to or becomes available to me or my dependents, I must notify the Fund office immediately.

_____	_____
Participant's Name (Please Print)	**Last Four Digits of Participant's Social Security Number**
_____	_____
Participant's Signature	**Telephone Number (in case of questions only)**

_____

Date