2020

NORTHEAST CARPENTERS HEALTH FUND

ANNUAL COORDINATION OF BENEFITS (COB) & ENROLLMENT FORM

Please Return in the Enclosed Envelope **NO LATER THAN MARCH 1, 2020.**

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NORTHEAST CARPENTERS FUNDS

Please complete **all** sections.

1. Participant's Information

First Name	M.I.	Last Name	D.O.B.	SSN or UBC #

Street Address	City	State	Zip Code

Home Phone Number	Mobile Number	Email Address

Family Status

☐ Single ☐ Married ☐ Widowed

☐ Divorced ☐ Date of Divorce _____

☐ Children ☐ No Children

2. Participant's Additional Coverage Information (If Applicable)

Do you the Participant have any other coverage besides your Northeast Carpenters Health Insurance? YES NO

☐ Coverage Through Spouse ☐ Privately Purchased ☐ State Assistance ☐ Medicare ☐ Other:_____

Insurance Company:_____ Policy Number:_____

Policy Holder:_____ Policy Holder D.O.B._____

Effective Date:_____ Type Of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

Participant Statement:

It is my responsibility, to ensure that all accurate information is maintained and kept updated regarding any Health Insurance. If other coverage is added or terminated for any individuals covered under my Group Insurance Program, I will notify the Fund immediately.

I have read this Enrollment/COB Form and I understand that the Northeast Carpenters Health Fund ("Fund") is an Employee Welfare Benefit Plan as defined under Employee Retirement Income Security Act of 1974 ("ERISA). I understand that any misrepresentation in the information I have provided above will permit the Fund to terminate the coverage of my Spouse, Minor Children, and/or Adult Children and seek any other legal remedies available including possible prosecution for fraud. I authorize the Fund to request and receive any Explanation of Benefits information from Independence Administrators. I am aware, and fully understand that if my Spouse has the capability to participate in, or purchase Health Coverage through their Employer; my Spouse is considered ineligible to receive Primary Health Care Coverage from the Northeast Carpenters Health Plan. I agree to immediately notify the Fund if my Spouse becomes eligible for Employer Offered Health Insurance. I authorize the Northeast Carpenters Health Fund to exchange contact information only (Change of Address, Telephone Numbers, E-mail Addresses, etc.) with your respective Union.

X_____ _____

Signature of Participant **Date**

☐ I would like to receive future correspondence from the Fund via E-mail and Text

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Spouse Information

NORTHEAST CARPENTERS FUNDS

Please complete **all Participant Spouse** sections.

Please indicate whether you wish to enroll or opt out your Spouse in the Coverage provided by the Fund for the upcoming benefit year (April 2020 — March 2021)

1. Spouse's Personal Information

Enroll	Opt Out	First Name	M.I.	Last Name	Sex

Social Security Number	Date of Birth	Date of Marriage

Mobile Number	Email Address

2. Spouse's Additional Coverage Information (If Applicable)

Policy Holder's Name:_____ Insurance Company:_____

Policy Number:_____ Effective Date:_____

Please list all who are covered under this plan:_____

_____

Insured By: ☐ Employer Provided ☐ Privately Purchased ☐ State Assistance ☐ Medicare ☐ Retiree

☐ Other:_____

Type Of Coverage: ☐ Single ☐ Family

Benefits Covered: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

Participant Statement:

Along with the information on this page, every spouse must complete the top portion of the Spouse Employment Verification Form located on page 7, whether you are employed or not employed. If employed, the Employer Section of page 7 must also be completed by the employer. **If employer offered insurance has been elected and copies of the card are included on Page 12, your employer does not need to sign Page 7.** The Spouse Employment Verification Form must be returned along with the 2020 Coordination of Benefits form. If not included, the entire Coordination of Benefits Form will be returned as incomplete. Failure to elect employer offered coverage will result in loss of Primary Coverage through the Fund and no payment for claims.

To enroll your Spouse for the first time, please include a copy of their Birth Certificate, Social Security Card and Marriage Certificate.

X_____ _____

Signature of Spouse **Date**

☐ I would like to receive future correspondence from the Fund via E-mail and Text

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NORTHEAST CARPENTERS FUNDS

2020 SPOUSE EMPLOYMENT VERIFICATION FORM

Participant Name: _____ UBC # or Last Four of SSN:_____

Spouse Name:_____ Spouse's Date of Birth:_____

1. Spouse's Employment Status

☐ Not employed ☐ Retired ☐ Medicare

☐ Self Employed - Name and type of business _____

☐ Employed **(If you have included a copy of your Insurance Cards, your Employer does not need to complete the Employer Section below.)**

2. Employer Section (If Applicable)

Employee Name _____

☐ Employee is currently in a Waiting Period/ Open Enrollment. Employee will be eligible: _____

☐ Employee did not elect to enroll in Health Benefits.

☐ Employee works 30 hours or less a week.

☐ Health coverage is offered, but without contributions toward the premium cost. (Must submit proof.)

☐ Health Coverage is not offered. Please Explain: _____

☐ Other: Please Explain: _____

Employer Name:_____

I hereby certify the person stated on this form is an Employee and the information above is accurate and complete to the best of my knowledge.

Employer Representative Signature and Name Printed: _____

E-Mail: _____ Phone Number: _____

PARTICIPANT/SPOUSE AUTHORIZATION AND SIGNATURES (IN ORDER FOR THIS FORM TO BE COMPLETE BOTH MUST SIGN)

We hereby declare under penalty of perjury that we are legally married and the information on this form is correct and complete to the best of our knowledge. We authorize the Northeast Carpenters Health Fund to verify the spouse's employment status as needed. If requested by the Fund, we agree to obtain and furnish a copy of any marriage certificate, divorce decree, or other relevant document. We understand that if any incorrect or misleading information results in a loss to the Fund, the Fund is entitled to recover the amount of such loss from us or by withholding from our future benefits. Employed Spouses Only: I hereby authorize my employer or other entities to release information regarding my employer's health insurance plan and my eligibility status for coverage under that plan to the Fund.

Participant Signature: _____ Date: _____

Spouse Signature: _____ Date: _____

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Dependent Information: Child(ren) (Age 0-26)

Please list all Children age 0-26 below, and indicate whether you wish to **Enroll or Opt Out** anyone for Health Insurance provided by the Fund for the 2020 Plan Year.

In order to enroll a Child or Step Child for the first time, please submit a copy of the Child's Birth Certificate and Social Security Card to the Fund Office.

Enroll	Opt Out	First Name, Middle Initial, Last Name	Relationship to Member	Birth Date	Social Security Number

If any Child(ren) listed above has Health Insurance Coverage other than the Benefits provided by the Northeast Carpenters Health Fund, please complete the corresponding boxes below. **(Please provide copy of Insurance Cards)**

If any Child is on State Sponsored coverage, or their own plan, please indicate "Self" as Policy Holder
If any Child is employed and has coverage through their employer please indicate "Self" as Policy Holder

Covered Child_____ Policy Holder D.O.B._____

Policy Holder_____ Policy Holder Relationship to Child_____

Insurance Company _____ Policy Number_____

Coverage From ☐ Employer Provided ☐ Privately Purchased ☐ State Assistance Effective Date_____

Type Of Coverage: ☐ Single ☐ Family Benefits Covered: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

If additional boxes are needed please see reverse side.

Covered Child____ Policy Holder D.O.B.______________________

Policy Holder____ Policy Holder Relationship to Child________________

Insurance Company ____ Policy Number___________________________

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date________________

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

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Covered Child____ Policy Holder D.O.B.______________________

Policy Holder____ Policy Holder Relationship to Child________________

Insurance Company ____ Policy Number___________________________

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date________________

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

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Covered Child____ Policy Holder D.O.B.______________________

Policy Holder____ Policy Holder Relationship to Child________________

Insurance Company ____ Policy Number___________________________

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date________________

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

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Covered Child____ Policy Holder D.O.B.______________________

Policy Holder____ Policy Holder Relationship to Child________________

Insurance Company ____ Policy Number___________________________

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date________________

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

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Covered Child____ Policy Holder D.O.B.______________________

Policy Holder____ Policy Holder Relationship to Child________________

Insurance Company ____ Policy Number___________________________

Coverage From ☐ Employer Provided ☐ Privately Purchased ☐ State Assistance Effective Date________________

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

2020 Coordindation of Benefit Document Checklist

Signatures and Enrollment:

- ☐ Are all applicable pages (3, 5, and 7) requiring signatures signed and dated?
- ☐ Did you check off the applicable ENROLL / OPT OUT boxes for all Eligible Family Members (spouse and child(ren) 0-26) that you wish to have covered by the Fund for the 2020 plan year?

Enrolling a Dependent for the first time? Please send a copy of the following documents:

- ☐ Spouse - Marriage Certificate, Spouse's Birth Certificate and Social Security Card.
- ☐ Child(ren) - Birth Certificate and Social Security Card.
- ☐ Step Child(ren) - Birth Certificate and Social Security Card.

Upload your documents fast and easy at ncf.carpenters.fund

Additional Documents you may need to send to the Fund:

- ☐ Spouse Employment Verification Form - This form **MUST** be returned , completed and signed, whether your spouse is employed or not.
- ☐ If you or your Spouse are currently enrolled in Medicare, please provide the Fund Office a copy of the card if you have not previously done so.
- ☐ Please include a copy of all Insurance Cards for any Eligible Family Member(s) other than the Insurance provided by the Fund.

Participant Name: _____ SSN/UBC # :_____

Copy of any **OTHER**
Health Insurance Card

Copy of any **OTHER**
Health Insurance Card

Copy of any **OTHER**
Health Insurance Card

Copy of any **OTHER**
Health Insurance Card