IBEW

INTERNATIONAL BROTHERHOOD OF ELECTRICAL WORKERS LOCAL NO. 150 FRINGE BENEFIT FUNDS

IBEW Local No. 150 Welfare Fund
IBEW Local No. 150 Pension Fund
IBEW Local No. 150 Vacation Fund
IBEW Local No. 150 Supplemental Pension Fund

Managed for the Trustees by:
TIC INTERNATIONAL CORPORATION

May 2018

YOUR RESPONSE TO THIS LETTER IS REQUIRED. PLEASE RETURN THE ENCLOSED YEARLY COORDINATION OF BENEFITS FORM BY JUNE 28, 2018
PENDING AND/OR FUTURE CLAIMS WILL NOT BE PROCESSED UNTIL THIS FORM HAS BEEN RETURNED

TO: ALL PLAN PARTICIPANTS OF THE IBEW LOCAL NO. 150 WELFARE FUND

RE: COORDINATION OF BENEFITS (COB) PROVISIONS

Dear Participant:

COORDINATION OF BENEFITS (COB) PROVISIONS

The Plan provides for Coordination of Benefits (COB) which helps save the Fund from paying for expenses that are already covered by another health insurance or Health and Welfare Plan. When properly administered, COB will help to curb needless increases in the cost of coverage for all the Plan participants.

The Coordination of Benefits provisions of the Plan provide the following:

- If the spouse of the Fund participant has coverage elsewhere, that coverage will be the primary payor of benefits for the spouse.
- If the eligible dependent children of the Fund Participant are covered under another group Health Plan, the order of benefits will be determined using the insurance industry standard practice based on the parent whose birth date occurs first in the year. For example, if the Fund participant's birth date is in June and his/her spouse's birth date is in March, then claims for dependent children will be processed first under the spouse's coverage and then under Fund coverage.
- Dependent coverage following divorce or re-marriage will be determined by individual legal consideration; please contact the Fund Office for benefit determination if this applies to you or your dependents.

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Administrative Office:
TIC International Corporation
6525 Centurion Drive
Lansing, MI 48917-9275
Toll-free (877) 478-4542
(517) 321-7508 Fax

Web Site:
http://www.ibew150benefits.org

Members Service Office:
IBEW Local Union No. 150 Fringe Benefit Funds
31290 N. US Highway 45 Unit B
Libertyville, IL 60048
(847) 680-0032
(847) 680-0219 Fax

In an effort to assure that the Fund has the most accurate information available regarding you and your dependents, ***you must complete the enclosed Yearly Coordination of Benefits and Dependent Status Statement and return it to the Medical Claims Office in the enclosed envelope on or before June 28, 2018. Pending and/or future claims will not be processed until this form has been returned.***

If you have any questions regarding the above, please do not hesitate to contact the Customer Service Department of the Medical Claims Office, toll free (877) 478-4542 or at the address listed below.

Sincerely,

BOARD OF TRUSTEES,
IBEW LOCAL NO. 150 WELFARE FUND

Enclosures

IBEW LOCAL NO. 150 WELFARE FUND

Managed for the Trustees by: TIC INTERNATIONAL CORPORATION

HEALTH CARE ENROLLMENT FORM AND YEARLY COORDINATION OF BENEFITS AND DEPENDENT STATUS STATEMENT

(Please Type or Print Clearly)

Participant's Name | Birthdate: | Member ID or SSN | Telephone number

Address: ☐ Check if new

MARITAL STATUS (Circle One): **Married** **Single** **Divorced** **Widow** **Separated**

Spouse's Name | Birthdate | Social Security No.

Dependent's Name | Relationship | Birthdate | Social Security No.

FAMILY CONTINUATION COVERAGE

-NOTE: PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHILDREN 19-26 ON THE REVERSE SIDE OF THIS FORM-

Are you or your dependents covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Circle One Yes No If Yes, please complete the section below:

Is this policy (Circle One) Group Individual

Name of Other Insurance Company | Telephone Number

Address of Other Insurance Company | Effective Date

Policy Number | Group Number | Policyholder's Name

Dependents Covered under the Policy

Are you or your dependents covered by any other dental insurance?

Circle One Yes No If Yes, please complete the section below:

Is this policy (Circle One) Group Individual

Name of Other Insurance Company | Telephone Number

Address of Other Insurance Company | Effective Date

Policy Number | Group Number | Policyholder's Name

Dependents Covered under the Policy

Are you or your dependents covered by any other vision insurance?

Circle One Yes No If Yes, please complete the section below:

Is this policy (Circle One) Group Individual

Name of Other Insurance Company | Telephone Number

Address of Other Insurance Company | Effective Date

Policy Number | Group Number | Policyholder's Name

Dependents Covered under the Policy

PLEASE READ CAREFULLY AND SIGN BELOW

I hereby certify that the above statements are true and complete to the best of my knowledge and belief. I understand that if I intentionally falsify any of the above information, medical claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of any change.

Member's Signature: **Date:**

Spouse's Signature: **Date:**

Return this form to: IBEW LOCAL NO. 150 WELFARE FUND, 6525 Centurion Drive, Lansing MI 48917

IBEW LOCAL NO 150 WELFARE FUND

ADULT CHILD UNDER AGE 26

PLEASE LIST ALL ELIGIBLE ADULT DEPENDENT CHLDREN 19-26 BELOW

(If you have more than two adult children under age 26, please use a separate sheet of paper)

The Health Care and Education Affordability Reconciliation Act of 2010 requires the Fund to extend dependent child coverage up to age 26. Adult dependent children qualify for coverage whether they are married or unmarried. As of July 1, 2014, if your dependent has another offer of employer-based coverage (such as through his or her job) they are still eligible to enroll under this Plan.

______________________________ ______________________________

NAME OF ADULT CHILD **SOCIAL SECURITY NUMBER**

______________________________ ______________________________

COMPLETE ADDRESS OF ADULT CHILD **BIRTH DATE**

FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Circle One Yes No If Yes, please complete the section below:

Is your adult child ***eligible to enroll*** in employer-based coverage? Yes No

If yes, is your adult child enrolled in employer-based coverage? Yes No

If Yes, please complete the section below

Effective date of other medical insurance:______________________________Is this policy (circle one) Group or Individual?

____

Name of Other Insurance Company Telephone Number

____

Address of Other Insurance Company

____

Policy Number Group Number Policyholder's Name

____

Dependents Covered under the Policy

____

____

______________________________ ______________________________

NAME OF ADULT CHILD **SOCIAL SECURITY NUMBER**

______________________________ ______________________________

COMPLETE ADDRESS OF ADULT CHILD **BIRTH DATE**

FAMILY CONTINUATION COVERAGE

Is your adult child under age 26 covered by any other medical insurance? This includes Medicare, Blue Cross Blue Shield, HMO Plans, PPO Plans, etc.

Circle One Yes No If Yes, please complete the section below:

Is your adult child ***eligible to enroll*** in employer-based coverage? Yes No

If yes, is your adult child enrolled in employer-based coverage? Yes No

If Yes, please complete the section below

Effective date of other medical insurance:______________________________Is this policy (circle one) Group or Individual?

____

Name of Other Insurance Company Telephone Number

____

Address of Other Insurance Company

____

Policy Number Group Number Policyholder's Name

____

Dependents Covered under the Policy

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