UFCW NATIONAL H & W FUND
66 GRAND AVENUE
ENGELWOOD, NJ 07631

DATE:

LOCAL:
INSURED: EMPLOYER/EN:
PATIENT: CLAIM#:
PROVIDER: UFN#:
CHARGES: DATE OF SERVICE:

Dear Member/Insured:

Because of changing family circumstances that may affect medical coverage, this important information is required each year to update our records. Your health care coverage includes a Coordination of Benefit provision that determines which coverage pays first when you are covered by more than one plan. In order for us to process your claim(s), we need the following information to determine the primary carrier for the patient on this claim. The claim cannot be processed without the requested information.

PLEASE FILL OUT THIS FORM IN ITS ENTIRETY FOR ALL FAMILY MEMBERS AND SIGN BELOW.

1. Name of spouse:
   _____

   Social Security Number of spouse:
   _____

   Date of Birth of spouse:
   _____

2. Is your spouse employed? NO ___ YES ___ (If NO, please skip to question #7)
   Please provide name and complete address of your spouse's employer.

   _____

3. Does your spouse's employer offer medical coverage of any type?
   NO ___ YES ___ SINGLE ___ or FAMILY ___

4. Is there a cost to your spouse for this coverage?
   No _____ Yes _____ Amount $_____/month

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(continued)

ID#:
CLAIM#:

Provide full name and address of spouse's insurance company (including ID # and Group Number).
_____
_____

5. Did your spouse decline medical coverage offered by his/her employer?
   NO ___ (continue to #6) YES ___

   a) Did your spouse receive any economic inducement, incentive or benefit for declining coverage offered by your spouse's employer. No_____ Yes_____ (If yes, please describe the inducement. (direct payment, contribution to a Flexible Spending Account, other benefits (child care, etc.)
   _____
   (Continue to question #7)

6. What was the effective date of your spouse's coverage: Month____ Day____ Year _____

7. Please list First and Last name(s) of ALL dependents (including spouse) that are included in your coverage.
   _____
   _____
   _____

8. If both you and Spouse are not the children's natural parents, please complete the following: (If divorced, please provide copy of divorce decree.)

Child's Name (Last & First)	Custodial Parent	Court ordered Payment of Healthcare Expense ___ Yes ___ No	Parent's Name	Insurance Carrier

I HEREBY CERTIFY THAT THE ABOVE INFORMATION GIVEN BY ME IS TRUE AND CORRECT.

Insurance disclaimer

Employee's signature: _____ Date: _____

Very Truly Yours,

Claims Processing Department