UFCW NATIONAL FUND
small enough to care...BIG enough to make a difference!®

66 Grand Avenue • Englewood, New Jersey 07631-3545
(201)569-8801 • Fax (201) 569-1085 or JFax@UFCWS.com

DATE:

MEMBER:
PATIENT: CLAIM#:
PROVIDER: ID#:
CHARGES: DATE OF SERVICE:

Dear Participant:

Under the Patient Protection and Affordable Care Act, your health care coverage as a dependent under this plan is available to you if you are between the ages of 19 and 26. In order for us to process your claim(s), we need the following information to determine continued eligibility for dependent coverage.

PLEASE FILL OUT THIS FORM IN ITS ENTIRETY AND SIGN BELOW.

Adult Dependent's Information

Dependent's Full Name: _____
Social Security #: _____ Sex: ____M ____ F
Address (if different from member): _____
City: _____State: _____ Zip Code: _____
Home #: _____ Cell #: _____
Are you employed? ☐ Yes ☐ No

Please indicate in the following sections if your Adult Dependent can receive health insurance through another insurer. Fill out all that apply:

1. **Employer Health Plan**

Can your Adult Dependent receive health insurance through his/her employer? ☐ Yes ☐ No
If they can, do they currently receive it? ☐ Yes ☐ No

Please provide the following information:

- Employer's Full Name: _____
  Employer's Address: _____
  City: _____State: _____ Zip Code: _____
  Employer's Telephone #: _____
  Please Indicate the Type of Coverage (Check all that apply):
  ____Medical ____ Hospital ____ Prescription ____ Dental ____ Vision
  Effective Date of Coverage: ____ / ____ /_____
  Month Day Year
- Name of Insurance Plan: _____
  Policy/Group #: _____
  Insurance Plan Telephone: _____– _____ – _____

2. **Adult Dependent's Other Parent's Health Plan**

Can your Adult Dependent receive health insurance through his/her other parent's employer?
☐Yes☐No If yes, please provide the following information:

- Parent's Full Name: _____
  Parent's Date of Birth: _____ / ____ /_____
  Month Day Year
- Employer's Full Name: _____
  Employer's Address: _____
  City: _____State: _____ Zip Code: _____
  Please Indicate the Type of Coverage (Check all that apply):
  ____Medical ____ Hospital ____ Prescription ____ Dental ____ Vision
  Effective Date of Coverage: _____ / ____ /_____
  Month Day Year
- Name of Insurance Plan: _____
  Policy/Group #: _____
  Insurance Plan Telephone: _____– _____ – _____

3. **Adult Dependent's Spouse's Health Plan**

Does your Adult Dependent receive health insurance through his/her spouse's employer?
☑Yes☐No If yes, please provide the following information:

- Spouse's Full Name: _____
  Spouse's Date of Birth: _____ / ____ /_____
  Month Day Year
- Employer's Full Name: _____
  Employer's Address: _____
  City: _____State: _____ Zip Code: _____
  Please Indicate the Type of Coverage (Check all that apply):
  ____Medical ____ Hospital ____ Prescription ____ Dental ____ Vision
  Effective Date of Coverage: _____ / ____ /_____
  Month Day Year
- Name of Insurance Plan: _____
  Policy/Group #: _____
  Insurance Plan Telephone: _____– _____ – _____

This coordination of benefits form is for Fund use only, and it will not be released to any third party except where necessary for the administration and operation of the Fund, or where otherwise required by law. The foregoing statements are to the best of my knowledge true and complete. I authorize any hospital, physician or other healthcare provider to release to the Fund and its agents any records of information, without restriction, concerning me or any member of my family receiving benefits from the Fund. Unless I revoke it in writing, this authorization will be effective as long as I am a participant in the Fund. A photocopy of this authorization shall be as valid as the original. I understand that under the terms of the plan (SPD), the Fund has a right to be reimbursed for any money it pays on my behalf for expenses caused by a third party. If the Fund pays any such claims, it will have a lien on payments I receive from, or on behalf of, the third party. This agreement will be effective for all benefits incurred while I am a participant in the Fund, even if I receive payments from, or on behalf of, a third party when I am no longer a participant.

I certify that the foregoing is true and correct.

Member's Signature _____Date:_____

Adult Dependent's Signature _____Date:_____

Failure to respond will create a gap in coverage for the Adult Dependent.