WISCONSIN ELECTRICAL EMPLOYEES BENEFIT FUNDS

2730 DAIRY DRIVE • SUITE 101 • MADISON, WI 53718 • PHONE (608) 276-9111 • (800) 422-2128
RECEIVING FAX (608) 276-9103 • HEALTH CLAIM FAX (608) 288-9095
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NATIONAL ELECTRICAL CONTRACTORS ASSOCIATION WISCONSIN CHAPTER

COORDINATION OF BENEFITS QUESTIONNAIRE

NOTE: To be completed by anyone covered under the Wisconsin Electrical Employees Benefit Fund that has other health insurance coverage (Member, Spouse, Dependents etc.).

SECTION 1: Your Wisconsin Electrical Employees Benefit Fund Information

Participant Name:	ID Number:

Are you or any of your covered dependents covered by another group health care plan, including Medicare?

☐ **NO** – Please skip the rest of the questions. Sign at the bottom and return

☐ **YES** – Please complete entire form, sign at the bottom and return

SECTION 2: Other Health Coverage Information - *Please provide the following information about the policy holder of the other health coverage.*

Name of Policy Holder of other coverage	Relationship to you	Social Security #	Employer	Date of Birth

Insurance Company Name	Address	City	State	Zip

Policy Number	Group Number	Effective Date	Cancellation date(if applicable)

Type of Coverage		Type of Plan (circle all that apply)
☐ Single ☐ Family	Is this a Retiree Contract? ☐ Yes ☐ No Is this a Cobra Contract? ☐ Yes ☐ No Is this an HMO policy? ☐ Yes ☐ No	Hospital Medical Dental Vision Drug Medicare

Who is covered by this other plan? Include yourself if applicable.

	Name (first and last)	Relationship to you		Name (first and last)	Relationship to you
1.			4.		
2.			5.		
3.			6.		

Section 3: Special Situations – *Fill out this section only if any of your children have health care coverage in addition to the above because of divorce, separation, etc...*

Is there a court order that determines responsibility for health care coverage or custody? ☐ Yes ☐ No
(attach a copy of the sections that apply to health care responsibility and/or custody arrangements, unless sent in already)

Name of person responsible for child's health care coverage	Social Security #	Employer	Date of birth

Insurance Co. Name	Address	City	State	Zip

Enrollee ID / Policy Number	Group Number	Effective Date	Cancellation Date

Which Children are covered by this insurance?

	Child's name (first and last)	Who has custody		Child's name (first and last)	Who has custody
1.			4.		
2.			5.		
3.			6.		

Participants Signature:______________________________ **Date:**______________

Return completed forms to: WEEBF
2730 Dairy Drive Suite 101
Madison WI 53718

OR Fax: 608-276-9103