Please complete and return this form to the Electrical Workers Local 369 Benefit Fund, 906 Minoma Ave., Louisville, KY 40217. This information must be updated and on file in order to process any claims. Your cooperation in returning this form will avoid any unnecessary delay in processing your claims. If you have any questions, please contact the Fund Office at (502) 635-2611.

RE: GENERAL COORDINATION & NON-DUPLICATION OF BENEFITS
BASIC BENEFITS AND MAJOR MEDICAL BENEFITS

Do you or your spouse have any other Group Health Benefit Coverage? Yes_____ No_____

A. Name of Group Policy_____
B. Name of Insurance Carrier_____
Address_____
C. Name of Policy Holder_____
D. Policy # _____ Group #_____ Effective Date_____
E. Coverage Identification (please check one) Policy Holder Only_____
Family Coverage_____

Do you or spouse have any other Direct Pay Health Benefit Coverage? Yes_____ No_____

If yes, please complete the following.
A. Name of Insurance Carrier_____

Do you or your spouse have any other Group Dental Benefit Coverage? Yes_____ No_____

A. Name of Group Policy_____
B. Name of Insurance Carrier_____
Address_____
C. Name of Policy Holder_____
D. Policy # _____ Group #_____ Effective Date_____
E. Coverage Identification (please check one) Policy Holder Only_____
Family Coverage_____

Do you or spouse have any other Direct Pay Dental Benefit Coverage? Yes_____ No_____

If yes, please complete the following.
A. Name of Insurance Carrier_____

Do you or your spouse have any other Group Vision Benefit Coverage? Yes_____ No_____

A. Name of Group Policy_____
B. Name of Insurance Carrier_____
Address_____
C. Name of Policy Holder_____
D. Policy # _____ Group #_____ Effective Date_____
E. Coverage Identification (please check one) Policy Holder Only_____
Family Coverage_____

Do you or spouse have any other Direct Pay Vision Benefit Coverage? Yes_____ No_____

If yes, please complete the following.
A. Name of Insurance Carrier_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Member Signature_____ Date_____

Members Name (Please Print)_____ Social Security #_____