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                                   |         |
|---|---|---------------------------------|---------------------------------------|---------|
| 22 72 2. 70 at opouse have any outer droup fiedlin benefit coverage:  |   |                                 | No                                    |         |
| Α.  | Name of Group Policy                                |                                 |                                       |         |
| В.  | Name of Insurance Carrier                           |                                 |                                       |         |
|   | - 4.4   |                                 |                                       |         |
| C.  | Name of Policy Holder                               |                                 |                                       |         |
| D.  | Policy#   | _Group #                        | _Effective Date                       |         |
| E.  | Coverage Identification (please check one)          |                                 |                                       |         |
|   |   |                                 |                                       |         |
|   |   |                                 |                                       |         |
| Do you o  | r spouse have any other Direct Pay Health Benefit   | t Coverage?                     | Yes                                   |         |
|   |   |                                 | No                                    |         |
|   | ease complete the following.                        |                                 |                                       |         |
| Α.  | Name of Insurance Carrier                           |                                 | <del>_</del>                          |         |
|   |   |                                 |                                       |         |
| David Company of the |   |                                 |                                       |         |
| DO YOU O  | r your spouse have any other Group Dental Benef     | nt Coverage?                    | Yes                                   |         |
| Α   | Name of Group Bolicy                                |                                 | No                                    |         |
| . А.<br>В.  | Name of Group Policy                                |                                 |                                       |         |
| В.  | A dalagae   |                                 |                                       |         |
| c.  | Name of Policy Holder                               |                                 |                                       |         |
|   | Policy #  | Group #                         | _Effective Date                       |         |
|   | Coverage Identification (please check one)          | _Oroap #<br>_Policy Holder Only |                                       |         |
| _,  | services (places officer officer                    | Family Coverage                 |                                       |         |
|   |   | Turring Corcinga                |                                       |         |
| Do you o  | r spouse have any other Direct Pay Dental Benefit   | : Coverage?                     | Yes                                   |         |
|   |   |                                 | No                                    |         |
| If yes, ple   | ease complete the following.                        |                                 |                                       |         |
| A.  | Name of Insurance Carrier                           |                                 |                                       |         |
|   | -   |                                 |                                       | <u></u> |
|   |   |                                 |                                       |         |
| Do you or your spouse have any other Group Vision Benefit Coverage?   |   | it Coverage?                    | Yes                                   |         |
|   |   |                                 | No                                    |         |
| Α.  | Name of Group Policy                                |                                 | · · · · · · · · · · · · · · · · · · · |         |
|   | Name of Insurance Carrier                           |                                 |                                       |         |
|   |   |                                 | _                                     |         |
|   | Name of Policy Holder                               | C#                              | refeative Date                        |         |
|   | Policy # Coverage Identification (please check one) | _Group #<br>Policy Holder Only  | _Effective Date                       |         |
| E.  | coverage identification (please check one)          | :                               |                                       |         |
| ranny coverage  |   |                                 |                                       |         |
| Do you o  | r spouse have any other Direct Pay Vision Benefit   | Coverage?                       | Yes                                   |         |
| , , , , , , ,   | have any owner price tray vision benefit            |                                 | No                                    |         |
| If yes, please complete the following.  |   |                                 |                                       |         |
|   | 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 #                     |         |