COORDINATION OF BENEFITS

COMPLETE THIS FORM IN FULL IF YOU/YOUR SPOUSE OR CHILD HAVE OTHER HEALTH COVERAGE

KBT PARTICIPANT'S NAME (print) _____ SOCIAL SECURITY # _____

SPOUSE'S NAME (print) _____

NAME OF INSURED FOR OTHER INSURANCE: _____

RELATIONSHIP TO KBT INSURED: self _____ spouse _____ child _____ other _____

NAME OF INSURANCE COMPANY: _____

INSURANCE COMPANY ADDRESS: _____
Street city state zip

POLICY NUMBER: _____

COVERAGE IS: SINGLE or FAMILY? (please check) _____ _____ PRIVATE or GROUP POLICY? _____ _____

COVERAGE INCLUDES: (check covered benefits, must have effective dates)

MEDICAL _____ EFFECTIVE DATE _____ TERMINATION DATE _____

DENTAL _____ EFFECTIVE DATE _____ TERMINATION DATE _____

OPTICAL _____ EFFECTIVE DATE _____ TERMINATION DATE _____

DRUGS _____ EFFECTIVE DATE _____ TERMINATION DATE _____

IF COVERAGE IS TERMINATED IN THE FUTURE PLEASE NOTIFY THE KANSAS BUILDING TRADES HEALTH & WELFARE FUND OFFICE IMMEDIATELY.

FAILURE TO COMPLETE THIS FORM WILL DELAY THE PROCESSING OF YOUR CLAIMS. THANK YOU FOR YOUR COOPERATION. CONTACT THE FUND OFFICE IF YOU HAVE ANY QUESTIONS.