AUTOMOBILE MECHANICS' LOCAL 701
BENEFIT FUND OFFICE

361 S. FRONTAGE ROAD, SUITE 100 | BURR RIDGE, IL 60527

TELEPHONE: (708) 482-0110 | TOLL FREE: (800) 704-6270 | FAX: (708) 482-0184

MUST RETURN COMPLETED FORM TO HAVE CLAIMS PROCESSED

Benefit Information/Coordination of Benefits (COB) Sheet

This form must be completed fully. Please print clearly or type the information requested.

Participant's Name: _____ **Birth Date:** _____
Complete full name including middle initial

Social Security Number (Last Four Digits): _____ **OR ID Number #:**_____

Male/Female: _____ **Single/Married/Divorced/Legally Separated:** _____

Street Address: _____

City, State, Zip Code:_____

Home Phone #:_____**Cell Phone #:**_____

Email Address: _____

Please list dependents below

	Name (Last, First, M.I.)	DOB (Month/Date/Year)	Sex (M/F)	Social Security Number (Last Four Digits)
Spouse:				
Child:				
Child:				
Child:				
Child:				
Child:				
Child:				

- **NOTE – *If not already on file, you ARE required to submit a copy of the certified birth certificate(s) and social security card(s) for your spouse and/or children and a certified marriage certificate for your spouse.* If the last name is different from yours, please explain their relationship to you.**

YOU MUST NOTIFY THE FUND OFFICE AND SUBMIT THE REQUIRED DOCUMENTATION WITHIN 90 DAYS OF THE DATE THE DEPENDENT FIRST BECAME ELIGIBLE UNDER THE PLAN TO

(TURN OVER)

RECEIVE COVERAGE AS OF THAT DATE. IF YOU DO NOT PROVIDE THE REQUIRED DOCUMENTATION WITHIN THIS 90 DAY PERIOD, COVERAGE WILL BEGIN AS OF THE DATE THE DOCUMENTATION IS RECEIVED BY THE FUND OFFICE.

1. Does your spouse have other insurance/coverage? Yes_____ No_____

2. If yes, please complete ALL of the following:

Spouse's Insurance Co.:_____ Policy #:_____

Spouse's Effective Date of Other Insurance Coverage:_____

Date of Marriage:_____

3. Do any of your dependent children have other insurance/coverage? Yes_____ No_____

4. If yes, please complete ALL of the following:

Dependent's Name:_____

Dependent's Insurance Co.:_____ Policy #:_____

Dependent's Effective Date of Other Insurance Coverage:_____

Dependent's Name:_____

Dependent's Insurance Co.:_____ Policy #:_____

Dependent's Effective Date of Other Insurance Coverage:_____

(If necessary, please attach additional pages to provide information about your other dependents' insurance/coverage.)

I certify that the above answers and statements, including any accompanying statements are true and complete to the best of my knowledge and belief. I authorize any physician, medical examiner or practitioner, coroner, hospital, veterans administration hospital, clinic, other medical or medically-related facility, insurance or reinsuring company, consumer reporting agency, employer, school, or group policyholder having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of the insured of the family members for which claim is made, to give to AUTOMOBILE MECHANCS' LOCAL NO. 701 UNION AND INDUSTRY WELFARE FUND (the "Fund") or its legal representative, any and all such information a photocopy of this authorization shall be as valid as the original. I also understand that if the Fund overpays benefits to me, my spouse, my dependents, or to any recipient on my behalf, the Fund may, at its discretion, require immediate repayment of the overpaid benefits in full, offset the overpayment from current and future benefit payments to me, my spouse, and my dependents, or institute legal action to collect the overpayment. I further understand that if an overpayment results from misrepresentations made by or on behalf of the recipient of the benefits, the Plan may obtain reimbursement of interest, professional fees incurred, and other damages related to that overpayment.

Participant's Signature: _____ Date:_____

Spouse's Signature: _____ Date:_____

Please return this completed form to the Local #701 Benefit Fund Office ASAP in order to process any claims you or your dependents may have in a timely manner.