IRON WORKERS DISTRICT COUNCIL OF SOUTHERN OHIO & VICINITY BENEFIT TRUST
1470 Worldwide Place · Vandalia, Ohio 45377
Phone (937) 454-1744 · FAX (937) 454-5457
Toll Free: (800) 331-4277

Coordination of Benefits Form

If you or your dependents are covered by more than one medical, prescription, vision, or dental health plan, the Iron Workers District Council Benefit Trust coordinates benefits with other insurers to help you receive the full benefit of those plans. By coordinating benefits, we may be able to reduce your out-of-pocket expenses for covered services.

We request information regarding other insurance upon your initial enrollment and on an annual basis for verification of any changes that may have happened during the year. In order to prevent your claim from being delayed or denied, please complete this form and return it to us within 10 days. If you need help, or if you have any questions, please contact us at 937-454-1744 or toll-free at 800-331-4277.

For any recently terminated insurance coverage, please provide a letter from the insurance carrier showing the termination date. Insurance carriers are required to provide this information to all individuals as they lose coverage.

Section 1: Other medical insurance

Is there other **medical** insurance? ☐ Yes (If yes, complete the section below) ☐ No		
Subscriber name	Subscriber's ID or policy no.	Subscriber birth date
Other insurance carrier	Subscriber's address	
Other carrier's phone	Other carrier's effective date	Other carrier's termination date
Other insurance type: ☐ Group plan ☐ Retiree ☐ COBRA ☐ Individual ☐ Other _____		
Names of those covered by other insurance carrier		

Section 2: Other prescription insurance

Is there other **prescription** insurance? ☐ Yes (If yes, complete the section below) ☐ No		
Subscriber name	Subscriber's ID or policy no.	Subscriber birth date
Other insurance carrier	Subscriber's address	
Other carrier's phone	Other carrier's effective date	Other carrier's termination date
Other insurance type: ☐ Group plan ☐ Retiree ☐ COBRA ☐ Individual ☐ Other _____		
Names of those covered by other insurance carrier		

Section 3: Other dental insurance

Is there other **dental** insurance? ☐ Yes (If yes, complete the section below) ☐ No		
Subscriber name	Subscriber's ID or policy no.	Subscriber birth date
Other insurance carrier	Subscriber's address	
Other carrier's phone	Other carrier's effective date	Other carrier's termination date
Other insurance type: ☐ Group plan ☐ Retiree ☐ COBRA ☐ Individual ☐ Other _____		
Names of those covered by other insurance carrier		

Section 4: Other vision insurance

Is there other **vision** insurance? ☐ Yes (If yes, complete the section below) ☐ No		
Subscriber name	Subscriber's ID or policy no.	Subscriber birth date
Other insurance carrier	Subscriber's address	
Other carrier's phone	Other carrier's effective date	Other carrier's termination date
Other insurance type: ☐ Group plan ☐ Retiree ☐ COBRA ☐ Individual ☐ Other _____		
Names of those covered by other insurance carrier		

We appreciate the time you have taken to complete the information on this form.

Your signature below certifies that the information you have entered on this form is true and correct to the best of your knowledge. You agree to contact us immediately should changes occur with any of your coverage.

Signature of member		Date
Phone number of member	Email of member	
Anthem ID/Social Security number of member		