NY44 Health Benefits Plan Trust
www.ny44.e1b.org

BENEFIT ADMINISTRATOR USE ONLY
Date Received: _____
Date Entered into Bswift: _____

Other Insurance
Coordination of Benefits

Applicant Name: _____ Social Security Number: _____

Please complete this form if **You** or a **Family Member** have other health insurance coverage such as:

- Coverage through a spouse's employer
- Coverage through a former employer
- Union coverage (other than through your current employer)
- Medicaid (limited/low income)
- New York State Exchange
- Medicare (persons over age 65, under age 65 with certain disabilities)
- An open workers' compensation case
- A motor vehicle accident/injury

Other Medical Health Insurance Information Attach additional sheet if necessary; provide copy(ies) of ID cards to Employer.

Name of Person(s) with Other Insurance:

_____

(Last) (First) (M.I.) Social Security No.

_____

(Last) (First) (M.I.) Social Security No.

_____

(Last) (First) (M.I.) Social Security No.

_____

(Last) (First) (M.I.) Social Security No.

Name of Insurance Company:

_____

Address:

_____

Telephone Number:

_____

Policy ID #:

_____

Effective Date of Coverage:

_____

Coverage Includes (check appropriate boxes):

Medical ☐ Yes ☐ No Dental ☐ Yes ☐ No

Hospital ☐ Yes ☐ No Vision ☐ Yes ☐ No

Prescription ☐ Yes ☐ No

Workers' Compensation Claim

Date of Injury/Accident: _____

Name of Injured Person:

_____

(Last) (First) (M.I.) Social Security No.

Injury/Injuries:

_____

Employer's Name Telephone No.

_____

Employer's Compensation Carrier, Address, Telephone Number:

_____

_____

WCB No.: _____ Claim No. _____

No-Fault (Motor Vehicle Accident)

Date of Accident: _____

Family Members Involved:

_____

(Last) (First) (M.I.) Social Security No.

_____

(Last) (First) (M.I.) Social Security No.

Name of Insurance Company:

_____

Telephone Number: _____

Claim No.: _____

Medical Injuries: ☐ Yes ☐ No

Medicare Information – Complete if You, your Spouse or Dependent(s) have Medicare insurance; provide copy of ID card(s) to Employer

Applicant Name: _____ Medicare No. _____

Enrolled in Part A Hospital Coverage Effective Date: _____

Enrolled in Part B Medical Coverage Effective Date: _____

Reason for Medicare Eligibility: Over Age 65 ☐ Disabled (under 65 years old) ☐ Disabled but actively working ☐

I am Retired (Retirement Date): _____

I am Actively Employed: Full-time ☐ Part-time ☐ Do you have health insurance with the Employer listed below? ☐ Yes ☐ No

Employer Name, Address: _____

Spouse/Dependent: Name: _____ Medicare No. _____

Enrolled in Part A Hospital Coverage Effective Date: _____

Enrolled in Part B Medical Coverage Effective Date: _____

Reason for Medicare Eligibility: Over Age 65 ☐ Disabled (under 65 years old) ☐ Disabled but actively working ☐

Retired (Retirement Date): _____

Actively Employed: Full-time ☐ Part-time ☐ Do you have health insurance with the Employer listed below? ☐ Yes ☐ No

Employer Name, Address: _____