1199 NEW ENGLAND HEALTH CARE WELFARE FUND COORDINATION OF BENEFITS
2026 Plan Year

SECTION 1: PARTICIPANT INFORMATION

Participant Name: Last Name, First Name	**Birth Date:**	**Employment Status** Active ☐ Retired ☐	**If Retired**, Date of Retirement
Member ID or Social Security #		**Home/Cell Phone Number**:	

SECTION 2: OTHER HEALTH INSURANCE INFORMATION

Name of Policy Holder of other insurance: Last Name: / First Name:	**Birth Date:**	**Sex:** Male ☐ Female ☐	**Social Security #**	**Relationship to You** (If not self)

Name of Other Health Insurance Company:	**Policyholder Identification Number:**
Other Health Insurance Company Address:	**Other Health Insurance Company Phone #**

List Family Member(s) covered by other insurance plan(s). If more space is needed, please list additional members and relationship to you on the back of this form:

NAME OF FAMILY MEMBER	RELATIONSHIP TO MEMBER	DATE OF BIRTH	EFFECTIVE DATE OF COVERAGE

Coverage Type:
Group ☐ **Medical** ☐ Dental ☐ **Vision** ☐ **Drug** ☐

Coverage Cancellation Date(If Applicable):_____

SECTION 3: MEDICARE COVERAGE INFORMATION

Name of Medicare Participant: Last Name: _____ **First Name:** _____

Medicare # _____ **Relationship to you (Leave blank if self)** _____

Effective Date Part A: _____ **Effective Date Part B:** _____

Effective Date Part D: _____

Medicare Eligibility Due to:

Age ☐ **Disability** ☐ **End-Stage Renal Disease** ☐ **Initial Dialysis Date**: _____

SECTION 4: SIGNATURE AND DATE

I certify that the information furnished by me on this form is true and correct at this time and agree to inform the 1199 New England Health Care Employees Welfare Fund ("The Fund") of any changes.

Participant Signature: **Today's Date:**