MASTERS, MATES AND PILOTS PLANS

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COORDINATION OF BENEFITS INFORMATION

THIS FORM IS APPLICABLE TO SPOUSES WHO ARE EMPLOYED AND RECEIVING HEALTH COVERAGE THROUGH THEIR EMPLOYER.

The M.M.&P. Health and Benefit Plan coordinates benefits with other health plans to provide a combination of payments up to, but not exceeding, 100% of the Covered Individual's Allowable Expenses. If your spouse is employed and covered for health benefits, please complete this form, sign it and return it to the Plan Office. If this form is not on file with the Plan Office with all required supporting documents, the Plan will be unable to consider medical expenses for your spouse.

I. PARTICIPANT'S NAME:______________________ SOC. SEC. NO.______________________

MEMBERSHIP GROUP: ☐ OFFSHORE ☐ CNW ☐ PILOTS ☐ OTHER

II. NAME OF SPOUSE/DEPENDENT FOR WHOM COVERAGE IS BEING REQUESTED

____

SOC. SEC. NO.______________________ DATE OF BIRTH______________________

III. SPOUSE'S HEALTH COVERAGE INFORMATION

- I am not employed ☐
- I am employed but I am not receiving health coverage through my Employer ☐

If you checked either box, do not complete the balance of the form – just sign and date it

IV. I AM EMPLOYED/HAVE BEEN EMPLOYED AND RECEIVING HEALTH COVERAGE THROUGH MY EMPLOYER ☐

Current or Last Health Insurance Carrier

Name______________________________________

Address ____________________________________

____

Phone______________________________________

Dates of Coverage

From______________________________
To______________________________

NOTE: ENCLOSE CERTIFICATE OF COVERAGE

Benefits

I am currently covered for the following benefits:

☐ Major Medical ☐ Prescription Drugs ☐ Dental ☐ Vision

☐ Hearing ☐ Other, specify:____________________

Check Appropriate Box:

My policy provides for Coordination of Benefits	☐ Yes	☐ No
My policy abides by the Birthday Rule*	☐ Yes	☐ No
My health insurance covers my dependents	☐ Yes	☐ No

Names of all family members covered by health insurance:____________________

____

____

V. I ____________________ hereby represent that the above information is true and correct. I understand that if I have misrepresented the facts, the M.M.&P. Health and Benefit Trustees may disqualify me from coverage under the Plan.

____
SIGNATURE OF PARTICIPANT
(PARTICIPANT MUST SIGN IF
COVERAGE IS FOR A MINOR CHILD)

____
SPOUSE'S SIGNATURE

____
DATE

*Birthday Rule – The Health Plan covering the parent whose birthday falls earlier in the calendar year pays first. The Health Plan covering the parent whose birthday falls later in the year, pays second.

Under this Coordination of Benefits provision, a Covered Individual receives a combination of payments up to, but not exceeding one hundred percent (100%) of the Covered Individual Allowable Expense.

FORM 569C
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