MASTERS, MATES, AND PILOTS PLANS

Executive Director

Kenneth T. Ryan

700 Maritime Boulevard, Suite A
Linthicum Heights, MD 21090-1996

Email
Planoffice@mmpplans.com

Telephone
(410) 850-8500

Telefax
(410) 850-8655

COORDINATION OF BENEFITS INFORMATION

THIS FORM IS APPLICABLE TO ALL SPOUSES WHETHER OR NOT YOUR SPOUSE IS 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. Whether or not 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 ☐ Pensioner ☐ UIG-PMR ☐ UIG-GL&G ☐ AMG

☐ Pilots ☐ Offshore Administrative/ Office/School ☐ 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.

<u>Current or Last Health Insurance Carrier</u>

Name: _____

Address: _____

Phone: _____

Dates of Coverage:

From: _____ **To:** _____

NOTE: ENCLOSE YOUR 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
Rev. 8/25/26