PENSION, HOSPITALIZATION AND BENEFIT PLAN OF THE ELECTRICAL INDUSTRY

COORDINATION OF BENEFITS FORM

Participants of the Pension, Hospitalization and Benefit Plan of the Electrical Industry ("the Plan") are subject to the Coordination of Benefits ("COB") provision. Under this provision, you must notify the Plan of any other Group Health Plan coverage you or your eligible dependents may be enrolled in.

Please complete all applicable sections of this form, sign and return it to the Members' Records Department at the Joint Industry Board, located at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365.

SECTION 1: PARTICIPANT INFORMATION:

_____

Last Name First Name

_____

Social Security Number Date of Birth

_____

Address

SECTION 2: COORDINATION OF BENEFIT INFORMATION

If your dependent is a participant in another group health plan, please provide information about this coverage below:

1. Dependent's Name: _____

Name of Dependent's health plan: _____

Effective date of coverage: _____

Relation to Participant (check one): ☐ spouse ☐ child

2. Dependent's Name: _____

Name of Dependent's health plan: _____

Effective date of coverage: _____

Relation to Participant (check one): ☐ spouse ☐ child

SECTION 3: PARTICIPANT'S SIGNATURE

Please print and sign your name and date this form.

_____ _____

Sign Name Date

_____

Print Name