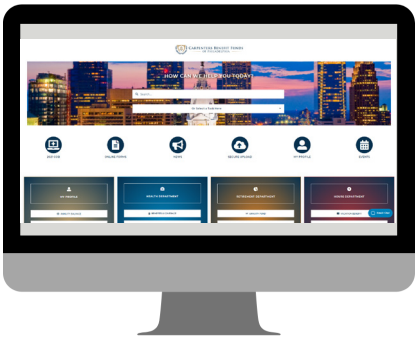
2023

EASTERN ATLANTIC STATES

CARPENTERS BENEFIT FUNDS

ANNUAL COORDINATION OF BENEFITS (COB) & ENROLLMENT FORM



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CARPENTERS.FUND

Or, please return this paper form in the enclosed envelope **NO LATER THAN NOVEMBER 1, 2023**

COB 2023 FAQS

What you need to know about the Coordination of Benefits (COB) & Enrollment Form

My Spouse is offered Health Insurance through their Employer, but would have to pay for it. Is my spouse still required to elect the coverage?

Yes. The Carpenter's Plan of Benefits states that if a spouse is offered health insurance through their Employer, regardless of part-time or full-time employment status, the Spouse is considered ineligible for Primary Coverage through the Carpenters Fund. However, once that spouse elects primary coverage either through their employer or elsewhere, they then become eligible for Secondary Insurance Coverage with the Carpenters Fund. Spouses are only required to elect major medical coverage, and only for themselves. Spouses are not required to sign up for elective coverages, nor must they cover the member or any eligible children.

What is the Spouse Employment Verification Form and why does it need to be filled out?

This form is used to help the Fund Office accurately update records with correct employment and insurance information. Every spouse must fill out the top portion and have the bottom portion completed by their employer. Please either upload this form along with all required documents online using the **"Secure Upload Center"** or mail to the Fund Office. Be sure the member's name and UBC number are on all documents. Forms completed online will be put on hold and considered incomplete until all documents are received. This could also result in your Vacation Benefit Payments being delayed.

What if my spouse loses employment?

The Fund would need a termination letter from the employer or the insurance company stating the last date of insurance coverage.

My information is the same as last year. Do I have to complete this form again?

Yes. The Fund may request new information each year. Although you may feel your household has not experienced any changes, it's important for the Fund Office to maintain the most up to date, accurate information as possible.

I am single with no children or spouse. Do I still need to complete this form?

Yes. All Participants must complete the annual Coordination of Benefits and Enrollment Form every year. If not completed, your Vacation Benefit Payments may be delayed.

I forgot to enroll or opt out a family member? Can I go back into the online Coordination of Benefits and make changes?

As long as your form has not been processed by the Fund Office, you may change or edit any of the COB Sections. Once your form is processed, you will not be able to go back and make any changes, you must contact the Fund Office at 732-417-3900.

2023 Participant Information

Please complete **all** sections.

1. Participant's Information

First Name	M.I.	Last Name	D.O.B.	SSN or UBC #

Street Address	City	State	Zip Code

Home Phone Number	Mobile Number	Email Address

Family Status

☐ Single
☐ Married
☐ Widowed

☐ Divorced
☐ Date of Divorce _____

☐ Children
☐ No Children

2. Participant's Additional Coverage Information (If Applicable)

Do you the Participant have any other coverage besides your EAS Carpenters Health Fund Insurance? YES NO

☐ Coverage Through Spouse ☐ Privately Purchased ☐ State Assistance ☐ Medicare ☐ Other:_____

Insurance Company:_____ Policy Number:_____

Policy Holder:_____ Policy Holder D.O.B._____

Effective Date:_____ Type Of Coverage: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

Participant Statement:

It is my responsibility, to ensure that all accurate information is maintained and kept updated regarding any Health Insurance. If other coverage is added or terminated for any individuals covered under my Group Insurance Program, I will notify the Fund immediately.

I have read this Enrollment/COB Form (pages numbered 1 through 10) and I understand that the Eastern Atlantic States Carpenters Health Fund ("Fund") is an Employee Welfare Benefit Plan as defined under Employee Retirement Income Security Act of 1974 ("ERISA). I understand that any misrepresentation in the information I have provided above will permit the Fund to terminate the coverage of my Spouse, Minor Children, and/or Adult Children and seek any other legal remedies available including possible prosecution for fraud. I authorize the Fund to request and receive any Explanation of Benefits information from Independence Administrators. I am aware, and fully understand that if my Spouse has the capability to participate in, or purchase Health Coverage through their Employer; my Spouse is considered ineligible to receive Primary Health Care Coverage from the Carpenters' Plan. I agree to immediately notify the Fund if my Spouse becomes eligible for Employer Offered Health Insurance. I authorize the Eastern Atlantic States Carpenters Health Fund to exchange contact information only (Change of Address, Telephone Numbers, E-mail Addresses, etc.) with your respective Union.

x_____ _____

Signature of Participant **Date**

☐ I would like to receive future correspondence from the Fund via E-mail and Text

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2023 Spouse Information

Please complete **all** **Participant Spouse** sections.

Please indicate whether you wish to enroll or opt out your Spouse in the Coverage provided by the Fund for the benefit year (April 2023 — March 2024)

To enroll your Spouse for the first time, please include a copy of their Birth Certificate, Social Security Card and Marriage Certificate.

1. Spouse's Personal Information

Enroll	Opt Out	First Name	M.I.	Last Name	Sex

Social Security Number	Date of Birth	Date of Marriage

Mobile Number	Email Address

2. Spouse's Additional Coverage Information (If Applicable)

Policy Holder's Name:_____ Insurance Company:_____

Policy Number:_____ Effective Date:_____

Please list all who are covered under this plan:_____

_____

Insured By: ☐ Employer Provided ☐ Privately Purchased ☐ State Assistance ☐ Medicare ☐ Retiree

☐ Other:_____

Type Of Coverage: ☐ Single ☐ Family

Benefits Covered: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

Along with the information on this page, every spouse must complete the top portion of the Spouse Employment Verification Form located on page 5, whether you are employed or not employed. If employed, the Employer Section of page 5 must also be completed by the employer. **If employer offered insurance has been elected and copies of the card are included, your employer <u>does not</u> need to sign.** The Spouse Employment Verification Form must be returned along with the 2023 Coordination of Benefits Form. If not included, the entire Coordination of Benefits Form will be returned as incomplete. Failure to elect employer offered coverage will result in loss of Primary Coverage through the Fund and no payment for claims.

X_____ _____

Signature of Spouse **Date**

☐ I would like to receive future correspondence from the Fund via E-mail and Text

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EASTERN ATLANTIC STATES
CARPENTERS BENEFIT FUNDS
WWW.CARPENTERS.FUND

New Jersey Location: 91 Fieldcrest Ave. Suite 25
Edison, NJ 08837 - (732) 417-3900

Philadelphia Location: 1811 Spring Garden St.
Philadelphia, PA 19130 - (215) 568-0430

2023 SPOUSE EMPLOYMENT VERIFICATION FORM

Participant Name: _____ UBC # or Last Four of SSN:_____

Spouse Name:_____ Spouse's Date of Birth:_____

1. Spouse's Employment Status

☐ Not employed ☐ Retired ☐ Medicare

☐ Self Employed - Name and type of business _____

☐ Employed **(If you have included a copy of your Insurance Cards, your Employer does not need to complete the Employer Section below.)**

2. Employer Section (If Applicable)

Employee Name _____

☐ Employee is currently in a Waiting Period. Employee will be eligible: _____

☐ Employee did not elect to enroll in Health Benefits. Next Open Enrollment period:_____

☐ Employee works 30 hours or less a week and is not eligible for benefits.

☐ Health coverage is offered, but without contributions toward the premium cost.
(Must submit cost of insurance and most recent paystub)

☐ Health Coverage is not offered. Please Explain: _____

Employer Name:_____

I hereby certify the person stated on this form is an Employee and the information above is accurate and complete to the best of my knowledge.

Employer Representative Signature and Name Printed: _____

E-Mail: _____ Phone Number: _____

PARTICIPANT/SPOUSE AUTHORIZATION AND SIGNATURES (IN ORDER FOR THIS FORM TO BE COMPLETE, BOTH MUST SIGN)

We hereby declare under penalty of perjury that we are legally married and the information on this form is correct and complete to the best of our knowledge. We authorize the Eastern Atlantic States Carpenters Health Fund to verify the spouse's employment status as needed. If requested by the Fund, we agree to obtain and furnish a copy of any marriage certificate, divorce decree, or other relevant document. We understand that if any incorrect or misleading information results in a loss to the Fund, the Fund is entitled to recover the amount of such loss from us or by withholding from our future benefits. Employed Spouses Only: I hereby authorize my employer or other entities to release information regarding my employer's health insurance plan and my eligibility status for coverage under that plan to the Fund.

Participant Signature: _____Date: _____

Spouse Signature: _____Date: _____

TO UPLOAD FORM ONLINE

SCAN ME!

WWW.CARPENTERS.FUND

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2023 Dependent Information: Child(ren) (Age 0-26)

Please list all Children age 0-26 below, and indicate whether you wish to **Enroll or Opt Out** anyone for Health Insurance provided by the Fund for the 2023 Plan Year.

In order to enroll a Child or Step Child for the first time, please submit a copy of the Child's Birth Certificate and Social Security Card to the Fund Office.

Enroll	Opt Out	First Name, Middle Initial, Last Name	Relationship to Member	Birth Date	Social Security Number

If any Child(ren) listed above has Health Insurance Coverage other than the Benefits provided by the Eastern Atlantic States Carpenters Health Fund, please complete the corresponding boxes below. **(Please provide copy of Insurance Cards)**

If any Child (Age 0-26) is on State Sponsored coverage, or their own plan, please indicate "Self" as Policy Holder
If any Child (Age 19-26) is employed and has coverage through their employer please indicate "Self" as Policy Holder

Covered Child_____ Policy Holder D.O.B._____

Policy Holder_____ Policy Holder Relationship to Child_____

Insurance Company _____ Policy Number_____

Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date_____

Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

If additional boxes are needed please see reverse side.

Covered Child______________________________ Policy Holder D.O.B.________________
Policy Holder______________________________ Policy Holder Relationship to Child______________
Insurance Company ______________________________ Policy Number__________________
Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date______________
Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

Covered Child______________________________ Policy Holder D.O.B.________________
Policy Holder______________________________ Policy Holder Relationship to Child______________
Insurance Company ______________________________ Policy Number__________________
Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date______________
Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

Covered Child______________________________ Policy Holder D.O.B.________________
Policy Holder______________________________ Policy Holder Relationship to Child______________
Insurance Company ______________________________ Policy Number__________________
Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date______________
Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

Covered Child______________________________ Policy Holder D.O.B.________________
Policy Holder______________________________ Policy Holder Relationship to Child______________
Insurance Company ______________________________ Policy Number__________________
Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date______________
Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

Covered Child______________________________ Policy Holder D.O.B.________________
Policy Holder______________________________ Policy Holder Relationship to Child______________
Insurance Company ______________________________ Policy Number__________________
Coverage From ☐ Employer Provided ☐Privately Purchased ☐State Assistance Effective Date______________
Type Of Coverage: ☐ Single ☐Family Benefits Covered: ☐Medical ☐ Dental ☐ Vision ☐ Prescription

2023 Coordination of Benefit Document Checklist

Signatures and Enrollment:

- ☐ Are all applicable pages requiring signatures signed and dated?
- ☐ Did you check off the applicable ENROLL / OPT OUT boxes for all Eligible Family Members (spouse and child(ren) 0-26) that you wish to have covered by the Fund for the 2023 plan year?

Enrolling a Dependent for the first time? Please send a copy of the following documents:

- ☐ Spouse - Marriage Certificate, Spouse's Birth Certificate and Social Security Card.
- ☐ Child(ren) - Birth Certificate and Social Security Card.
- ☐ Step Child(ren) - Birth Certificate and Social Security Card.

Upload your documents using the Secure Upload Center at carpenters.fund

Additional Documents you may need to send to the Fund:

- ☐ Spouse Employment Verification Form - This form **MUST** be returned, completed and signed, whether your spouse is employed or not.
- ☐ If you or your Spouse are currently enrolled in Medicare, please provide the Fund Office a copy of the card if you have not previously done so.
- ☐ Please include a copy of all Insurance Cards for any Eligible Family Member(s) other than the Insurance provided by the Fund.

Participant Name: _____ _____ SSN/UBC # :_____

Copy of any **OTHER**
Health Insurance Card

Copy of any **OTHER**
Health Insurance Card

Copy of any **OTHER**
Health Insurance Card

Copy of any **OTHER**
Health Insurance Card