



**Annuity • Pension  
Health • Training • S.U.B.**

**2026 Coordination of Benefits (COB)  
Participant Questionnaire**

1965 Dixwell Avenue, Hamden, Connecticut 06514  
Phone: 1-203-288-9261 Fax: 1-203-230-4450

**\*IMPORTANT DEADLINE \***

**COB information must be submitted to the Fund Office by January 31, 2026 or your dependent(s) claims may be delayed.**

ID: \_\_\_\_\_ Phone Number: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Number: ( \_\_\_\_\_ ) \_\_\_\_\_

**Coordination of Benefits (COB) Participant Questionnaire**

**It is important that you complete and return this form.** COB is a way to coordinate benefit payments when you or your eligible dependents are covered by more than one health plan. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Thank you.

Please answer the following question:

- **Are you, your spouse or any of your dependent children who are currently covered by the Fund's health plan also covered by any other health plan or Medicare?**

Yes  No

Please follow the instructions below:

**If Yes, to the above question:**

- For other health insurance plans, please complete sections 1 & 2.
- For Medicare coverage only, please complete sections 1 & 3.
- For other health insurance plans and Medicare, please complete sections 1, 2 & 3.

**If No, to the above question:**

- Please complete section 1 and sign your name.

**Please fully complete each required section and sign the form or your form will be returned.**

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**SECTION 1: TO BE COMPLETED BY ALL IUOE LOCAL 478 HEALTH BENEFITS FUND PARTICIPANTS**

IUOE Local 478 Participant Name (Last Name, First Name)	Birth Date	Employment Status Active <input type="checkbox"/> Retired <input type="checkbox"/>	Date of Retirement (if applicable)
Member ID Number or Social Security#		Phone Number	
I certify that the information furnished by me on this form is true and correct at this time and agree to inform IUOE Local 478 Benefit Fund of any changes.			
 IUOE Local 478 Participant Signature		Today's Date	

**SECTION 2: OTHER HEALTH INSURANCE INFORMATION**

Name of Policy Holder (Last Name, First Name)	Birth Date	Sex Male <input type="checkbox"/> Female <input type="checkbox"/>	Social Security #	Relationship to You
Name of Other Health Insurance		Policyholder Identification Number		
Other Health Insurance Address		Other Health Insurance Phone#		
Employment Status Active <input type="checkbox"/> Retired <input type="checkbox"/>	Employer's Name	Date of Retirement (if applicable)		
Type of Coverage Effective Date _____	Medical <input type="checkbox"/>	Drug <input type="checkbox"/>	Dental <input type="checkbox"/>	Vision <input type="checkbox"/>
Cancellation Date _____	_____	_____	_____	_____
Please list any other dependents covered by this other health insurance. If there are more than six, please check this box D and list the rest on the back of this form.				
1. (Last Name, First Name)	Relationship to You	4. (Last Name, First Name)	Relationship to You	
2. (Last Name, First Name)	Relationship to You	5. (Last Name, First Name)	Relationship to You	
3. (Last Name, First Name)	Relationship to You	6. (Last Name, First Name)	Relationship to You	

**SECTION 3: MEDICARE COVERAGE INFORMATION**

Name of Medicare Beneficiary (Last Name, First Name)		Social Security#
Medicare#	Type of Coverage Part A (Hospital) Effective Date: Part B (Medical) Effective Date: Part D (Drug) Effective Date:	Medicare Eligibility Due to Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease <input type="checkbox"/> Initial Dialysis Date
Name of Medicare Beneficiary (Last Name, First Name)	Social Security #	
Medicare#	Type of Coverage Part A (Hospital) Effective Date: Part B (Medical) Effective Date: Part D (Drug) Effective Date:	Medicare Eligibility Due to Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease <input type="checkbox"/> Initial Dialysis Date
<b>Participant Signature</b>	<b>Today's Date</b>	<b>Fax: 203-230-4450</b> <b>Mail: IUOE Local 478 Health Benefits Fund</b> <b>1965 Dixwell Avenue, Hamden, CT 06514</b>