

WEST VIRGINIA LABORERS TRUST FUND

PLAN OFFICE
WEST VIRGINIA LABORERS TRUST FUND
ONE UNION SQUARE
SUITE 200
CHARLESTON, WV 25302

Phone: (304) 342-5142
Fax: (304) 342-2610

AUTHORIZATION FOR COORDINATION OF BENEFITS

Section I: Participant Information

Name: _____ Soc. Sec. No: _____
Address: _____ Birth Date: _____
City: _____ State: _____ Zip Code: _____ Telephone: _____

Section II: Authorization Agreement – for Coordination of Benefits

If you or your spouse is covered under another Group Health Plan, please provide Company Name and Policy Number.

Company Name _____
Policy Number _____

Section III: Participant Signature

I (we) hereby authorize the Plan to coordinate medical insurance coverage with the above-named policy.

In witness, whereof, the undersigned has hereunto set his/her hand this ____ day of _____, 20____.

Signature: _____

PLEASE RETURN THIS FORM TO THE W.V. LABORERS' TRUST FUND WITHIN TEN (10) DAYS OF RECEIPT OF THIS LETTER. ANY CLAIMS INCURRED WILL BE HELD UNTIL THIS FORM HAS BEEN RECEIVED.

Section IV: Plan Office Use Only

Received on _____ by _____