SOUTHERN CALIFORNIA PIPE TRADES
HEALTH & WELFARE FUND
PENSIONERS & SURVIVING SPOUSES HEALTH FUND
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 386-0418 | Email info@scptac.org | www.scptac.org

2024

ANNUAL COORDINATION OF BENEFITS FORM

This form is required once per calendar year or upon change in other insurance. Benefits under these Plans will be coordinated with the other coverage you have under any other plan. If the plan determined to be your primary insurance is a prepaid HMO or PPO plan, and if you do not use that plan's contracted providers for services and supplies that are covered under that plan, the benefits payable under these Plans are reduced to 20%.

PART 1 Participant Information

NAME			
DATE OF BIRTH	*mm/dd/yyyy* / /	SOCIAL SECURITY NUMBER	*Only last four SSN digits required* - -
ADDRESS	*Street*	*City*	*State* *ZIP*
PHONE	( ) -	EMAIL	

Note: If your address on this form is different from your address on file with the Fund Office, your address will be changed for all five Southern California Pipe Trades Funds to the address on this form.

PART 2 Patient Information (if different from above)

NAME		RELATIONSHIP TO PARTICIPANT	
DATE OF BIRTH	*mm/dd/yyyy* / /	SOCIAL SECURITY NUMBER	*Only last four SSN digits required* - -
ADDRESS	*Street*	*City*	*State* *ZIP*

PART 3 Other Coverage or Benefits

Is the patient eligible for other coverage or benefits: (CHECK ONE) ☐ YES ☐ NO

If yes, what is the type of coverage: ☐ MEDICAL ☐ VISION ☐ OTHER:

POLICY HOLDER:	INSURANCE:
PLAN ID:	PHONE: ( ) -

PART 4 Authorization

I/We hereby certify that the foregoing statements, and any accompanying statements, are true, correct and complete to the best of my/our knowledge. I/We authorize any medical/health plan or issuer of an insurance policy under which I am eligible to receive medical/health benefits, to furnish the Southern California Pipe Trades health funds ("SCPT Funds"), upon their request, with information regarding benefits to which I/we may be entitled or have received. I/We further authorize any union or employer that has information about this other coverage to provide this information to the SCPT Funds.

PATIENT'S SIGNATURE *Not required if under 18 years of age* X	DATE / /
PARTICIPANT SIGNATURE X	DATE / /