LABORERS' BENEFITS • ST. LOUIS

Dependent Custody Form

2357 59th Street ● St. Louis, MO 63110 ● www.stllaborers.com
Phone 314-644-2777 ● Fax 314-646-4440 ● benefits@stllaborers.com

The medical coverage with the Greater St. Louis Construction Laborers' Welfare Fund Benefit Office contains a Coordination of Benefits (COB) provision. Processing of claims/services your dependent cannot be completed until this COB form has been completed, signed by the member, natural mother and natural father, and returned to the Benefit Office. Your delay or failure to return the COB form could result in the denial of claims/services under the Plan for your dependent(s).

Member:		**Medical Member ID#:**
Part One – Child:		
Social Security:	Date of Birth:	With whom does the child reside?
Home Address:	City & State:	Zip Code:
Part Two – Natural Father's Information:		
Name:	Date of Birth: SS#:	Phone Number:
Home Address:	City & State:	Zip Code:
Do you have other insurance coverage: ☐ **Yes** ☐ **No** Type of coverage: ☐ Single ☐ Family	**Please check all that apply:** ☐ Medical ☐ Dental ☐ Vision ☐ Prescription	
Name of Plan:	Effective Date: Member ID:	Phone Number of Plan:
Part Three – Natural Mother's Information:		
Name:	Date of Birth: SS#:	Phone Number:
Home Address:	City & State:	Zip Code:
Do you have other insurance coverage: ☐ **Yes** ☐ **No** Type of coverage: ☐ Single ☐ Family	**Please check all that apply:** ☐ Medical ☐ Dental ☐ Vision ☐ Prescription	
Name of Plan:	Effective Date: Member ID:	Phone Number of Plan:
Part Four – Step Parent's Information:		
Name:	Date of Birth: SS#:	Phone Number:
Home Address:	City & State:	Zip Code:
Do you have other insurance coverage: ☐ **Yes** ☐ **No** Type of coverage: ☐ Single ☐ Family	**Please check all that apply:** ☐ Medical ☐ Dental ☐ Vision ☐ Prescription	
Name of Plan:	Effective Date: Member ID:	Phone Number of Plan:

I understand that it is my responsibility to immediately notify the Benefit Office of any changes in the above information. I certify the above statements are true, complete and accurate to the best of my knowledge. I understand if anything is untruthful, it could result in my termination and/or termination of my dependents and recoupment by the plan. I authorize any physician, hospital, employer, insurance company, or other informant to furnish any information necessary to consider claims(s) on dependents and myself listed above. A photocopy of this authorization should be as valid as the original. If you have not already done so, please provide a copy of the divorce decree and/or court order showing who is responsible for insurance coverage and who has legal custody for the above dependent.

Signature of Member: _____ Date: _____

Signature of Natural Father: _____ Date: _____

Signature of Natural Mother: _____ Date: _____