LABORERS'
BENEFITS • ST. LOUIS

Dependent Custody Form

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

The medical coverage with the Greater St. Louis Construction Laborers' Welfare Fund Office (Benefit Office) contains a Coordination of Benefits (COB) provision. Processing of claims/services for your dependent(s) 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# or SS#:**

Child's Name:		
Child's Date of Birth:	With whom does the child reside?	Relationship with who the child resides?

Child's Home Address:	City & State:	Zip Code:

Natural Father's Name:

Natural Mother's Name:

Step-Parent's Name:

Step-Parent's Name:

Does the child listed above have any OTHER insurance coverage: ☐ Yes ☐ No
If you answered yes, please complete the insurance information below

Insurance Policy Information		
Policy holder's Name:		Policy holder's date of birth?
Name of Plan:	Member ID or policy number:	Customer Service Phone Number of Plan:
Effective Date:	Type of coverage: ☐ Single ☐ Family	**Please check all that apply:** ☐ Medical ☐ Prescription ☐ Vision ☐ Dental

Additional Insurance Policy Information *if applicable*		
Policy holder's Name:		Policy holder's date of birth?
Name of Plan:	Member ID or policy number:	Customer Service Phone Number of Plan:
Effective Date:	Type of coverage: ☐ Single ☐ Family	**Please check all that apply:** ☐ Medical ☐ Prescription ☐ Vision ☐ Dental

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.

If you do not have contact with one of the natural parents, please contact the Benefit Office (314) 644-2777 ext. 2.

Signature of Natural Father: _____ Date: _____

Signature of Natural Mother: _____ Date: _____

Signature of Step-Parent: _____ Date: _____

Signature of Step-Parent: _____ Date: _____