Airconditioning & Refrigeration Industry Joint Trust Funds
Coordination of Benefits Form *

Participant's Name: _____ **SSN# XXX-XX-**_____

Alternate Coverage for Dependents

In order to add dependents to your coverage, this form must be completed and returned along with the applicable certification for your dependent(s). Please indicate whether your spouse and/or dependent children are enrolled in alternate coverage by completing the information below and attaching any corresponding documentation.

Spouse's Name: _____ DOB: _____ Alternate Coverage? **YES** ☐ **NO** ☐

☐ If yes, please attach a photocopy of your spouse's medical ID card including the effective date.

Child's Name: _____ DOB: _____ Alternate Coverage? **YES** ☐ **NO** ☐

☐ If yes, please attach a photocopy of your child's medical ID card including the effective date.

Child's Name: _____ DOB: _____ Alternate Coverage? **YES** ☐ **NO** ☐

☐ If yes, please attach a photocopy of your child's medical ID card including the effective date.

Child's Name: _____ DOB: _____ Alternate Coverage? **YES** ☐ **NO** ☐

☐ If yes, please attach a photocopy of your child's medical ID card including the effective date.

Child's Name: _____ DOB: _____ Alternate Coverage? **YES** ☐ **NO** ☐

☐ If yes, please attach a photocopy of your child's medical ID card including the effective date.

I understand that it is the responsibility of myself and/or my dependents to notify the Trust Fund Office immediately when my dependents enroll in alternate coverage, or when such coverage is terminated. I understand it is my responsibility to notify the Trust Fun Office of any changes to the status of my dependents.

Authorization:

_____ _____

Participant's Signature **Date**