JOINT INDUSTRY BOARD OF THE ELECTRICAL INDUSTRY
158-11 HARRY VAN ARSDALE JR. AVENUE • FLUSHING, N.Y. 11365
TEL: (718) 591-2000 • FAX: (718) 380-7741

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Dear Participant:

Various benefits are administered through the Joint Industry Board, which provides coverage for both the participant and the eligible dependents of the participant.

Eligible dependents are 1) spouse and 2) unmarried children from birth up to their 19th birthday. However, full-time unmarried dependent students attending accredited institutions of higher learning shall be covered up to age 25 years. An original letter from the college registrar for the current semester shall be required as proof of current college attendance. The term "children" shall mean natural or legally adopted children.

The proper recording of your eligible dependents, and any other group health coverage available to them, will facilitate payment of future claims. Please complete the enclosed forms and return them in the enclosed envelope, with a copy of the applicable marriage certificate, birth certificate(s) or adoption papers so that your eligible dependents may be properly recorded and enrolled.

In order to avoid a delay in processing, please include Social Security numbers for all dependents.

PENSION, HOSPITALIZATION AND BENEFIT PLAN OF THE ELECTRICAL INDUSTRY

COORDINATION OF BENEFITS FORM

Participants of the Pension, Hospitalization and Benefit Plan of the Electrical Industry ("the Plan") are subject to the Coordination of Benefits ("COB") provision. Under this provision, you must notify the Plan of any other Group Health Plan coverage you or your eligible dependents may be enrolled in.

Please complete all applicable sections of this form, sign and return it to the Members' Records Department at the Joint Industry Board, located at 158-11 Harry Van Arsdale Jr. Avenue, Flushing, NY 11365.

SECTION 1: PARTICIPANT INFORMATION:

____

Last Name First Name

____

Social Security Number Date of Birth

____

Address

SECTION 2: COORDINATION OF BENEFIT INFORMATION

If your dependent is a participant in another group health plan, please provide information about this coverage below:

1. Dependent's Name: ____

Name of Dependent's health plan: _____________________________________

Effective date of coverage: ____________________________

Relation to Participant (check one): ☐ spouse ☐ child

2. Dependent's Name: ____

Name of Dependent's health plan: _____________________________________

Effective date of coverage: ____________________________

Relation to Participant (check one): ☐ spouse ☐ child

SECTION 3: PARTICIPANT'S SIGNATURE

Please print and sign your name and date this form.

________________________________ _________________

Sign Name Date

____

Print Name

DEPENDENTS BENEFIT FILE

SOC. SEC. # | | | | | | | | | |

I.D. 01

MEMBER'S NAME

LAST | FIRST

MEMBER'S DATE OF BIRTH | | | | | | | SEX

For Office Use Only

- ☐ NEW
- ☐ ADD DEPENDENT
- ☐ DELETE DEPENDENT
- ☐ CHANGE ONLY
- ☐ ELI FILE
- ☐ DEN FILE

EFFECTIVE DATE

01

ELIGIBLE DEPENDENT INFORMATION

For Office Use Only

	NAME	BIRTHDATE	SEX M or F	SOCIAL SECURITY #	COLLEGE DATE	EFFECTIVE DATE
02	SPOUSE NAME					
03	CHILD NAME	M D Y				
04	CHILD NAME	M D Y			M D Y	
05	CHILD NAME	M D Y			M D Y	
06	CHILD NAME	M D Y			M D Y	
07	CHILD NAME	M D Y			M D Y	
	CHILD NAME	M D Y			M D Y	

Member's Signature____ Date________________________________

ME-36