BAC Local #3 NY Buffalo Chapter Benefit Funds

1175 William Street
Buffalo, NY 14206
Phone: (716) 842-1318 Fax: (716) 842-1347

HEALTH INSURANCE COVERAGE INFORMATION FORM

Part A

Participant Name:
Social Security #

Part B

YOU MUST LIST THE PARTICIPANT AND ALL DEPENDENTS THAT ARE COVERED UNDER A QUALIFIED HEALTH INSURANCE PLAN (Continue on Back – If Necessary)

Name	**Insurance Co.**	**SSN**	**DOB**

Part C

YOU MUST ANSWER ALL QUESTIONS		
Are any of these plans through a Government Health Care Exchange? If so, please list the names of those insured:	YES	NO
Are any of these plans receiving a Premium Tax Credit/Discount from the Exchange? If so, please list the names of those insured:	YES	NO

Part D

I acknowledge that the information herein is true and that the Fund Office will rely on this information for the distribution of benefits. I understand that it is my responsibility to notify the Fund Office immediately and complete a new form should any changes to my or my dependents' health insurance coverage occur. I understand that it is fraudulent to falsify information and could result in penalties from the IRS.

Participant Signature: _____ **Date:** _____

PLEASE SEE REVERSE SIDE FOR INSTRUCTIONS. YOU MUST SUBMIT ADDITIONAL DOCUMENTATION WITH THIS FORM

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HEALTH INSURANCE COVERAGE INFORMATION FORM INSTRUCTIONS

Part A: You must list your name (member, prior-member or retiree who has the HRA or WRA account with the BAC Local #3 NY Buffalo) and social security number

Part B: You must list yourself (the participant) and all qualified dependents who currently have health insurance. You must also list their social security numbers and dates of birth, as we are required to report this information to the IRS each year. Please also list the name of the insurance company that each person is insured through (it is okay if all dependents do not carry the same insurance policy). If you or your dependents are covered under an insurance plan with the BAC Local #3 NY Buffalo, please write "BAC LOCAL #3" under Insurance Company for each dependent enrolled in our plan.

Part C: You must answer all of these questions. If you or your dependents are enrolled in a plan through the Government Health Exchange (ie. NYS of Health Marketplace), you must circle YES for the first question and list the names of those insured through the Government Health Exchange.
If you or your dependents are receiving a Premium Tax Credit to help pay for the health insurance through the Government Health Exchange you must circle YES to the second question and list the names of those receiving the Premium Tax Credit for their insurance.
If you and all your dependents are enrolled in a plan under your spouse or parent's employer, Native American coverage, or Veteran's coverage, please circle NO for both questions.

Part D: You, the participant (member, prior member or retiree with HRA or WRA account), must read the acknowledgement and sign and date the form. You must also include proof of health insurance for yourself and each dependent as backup: **You must provide an insurance card, dated in the current year, that lists the participant and each dependent. If you and your dependents are insured on different plans, we will need a copy of each health insurance card. You may also submit an insurance verification letter (from the insurance company or group policy) that lists you and your dependents who are covered under that plan for the current year.**

IF YOUR INSURANCE CARD DOES NOT HAVE A CURRENT YEAR EFFECTIVE DATE OR DOES NOT LIST ALL DEPENDENTS, YOU MUST SUBMIT A CURRENT INSURANCE VERIFICATION LETTER FOR YOU AND YOUR DEPENDENTS.