SOUTHERN CALIFORNIA PIPE TRADES
HEALTH & WELFARE FUND &
PENSIONERS & SURVIVING SPOUSES HEALTH FUND
501 Shatto Place, Suite 500, Los Angeles, CA 90020 | (800) 595-7473 (213) 385-6161 | Fax (213) 386-0418 | Email health@scptac.org | www.scptac.org

ANNUAL COORDINATION OF BENEFITS FORM

This form is required once per calendar year or upon a change in your medical benefits. Benefits will be coordinated with the other coverage you have under any other plan. If the plan determined to be your primary insurance is a prepaid HMO or PPO plan, and if you do not use that plan's contracted providers for services and supplies that are covered under that plan, the benefits payable under the SCPT Plans are reduced to 20%.

PART 1—PARTICIPANT INFORMATION

NAME			
DATE OF BIRTH	*mm/dd/yyyy*	SOCIAL SECURITY NUMBER	*Only last four SSN digits required*
ADDRESS	*Street*	*City*	*State* *ZIP*
PHONE		EMAIL	

Note: If your address on this form is different from your address on file with the Fund Office, your address will be changed for all five Southern California Pipe Trades Funds to the address on this form.

PART 2—PATIENT INFORMATION (if different from above)

NAME		RELATIONSHIP TO PARTICIPANT	
DATE OF BIRTH	*mm/dd/yyyy*	SOCIAL SECURITY NUMBER	*Only the last four SSN digits required*
ADDRESS	*Street*	*City*	*State* *ZIP*
PHONE		EMAIL	

PART 3—OTHER COVERAGE OR BENEFITS (this section is required)

Is the patient eligible for other coverage benefits? ☐ YES ☐ NO (CHECK ONE)

If yes, please provide policy details:

POLICYHOLDER:	INSURANCE:
PLAN ID:	PHONE:

PART 4--AUTHORIZATION

I/We hereby certify that the foregoing statements, and any accompanying statements, are true, correct, and complete to the best of my/our knowledge, and I/we agree to immediately notify the Fund of any changes to this information. I/We authorize any medical/health plan or issuer of an insurance policy under which I am eligible to receive medical/health benefits to furnish the Southern California Pipe Trades health funds ("Funds"), upon their request, with information regarding benefits to which I/we may be entitled or have received. I/We further authorize any union or employer that has information about this other coverage to provide this information to the Funds. If the signed date is for a prior calendar year, the date the form is received by the Fund Office will be used as the signature date for processing purposes, and the Funds will rely on this information to pay claims. I/we agree to reimburse the Funds to make them whole for any benefits not properly coordinated due to my/our failure to report a change.

PATIENT SIGNATURE *(Not required if under 18 years of age)* X	DATE
PARTICIPANT SIGNATURE X	DATE

Revised October 2026