LUTHERAN CHURCH–CANADA PENSION PLAN

WORKER BENEFIT PLANS

HIPP

CO-ORDINATION OF HEALTH AND DENTAL BENEFITS FORM

Member: _____
Surname Given Names & Initial

Worker I.D. _____

My spouse and/or dependent has coverage under another employer's Health and Dental plan as indicated below.

OTHER PLAN INFORMATION:

Name of Employer: _____

Name of Insurer: _____

Policy Number: _____

Effective Date: _____

Coverage for:

- Spouse only _____
- Spouse & member _____
- Spouse & dependents _____
- Spouse, member & dependents _____

I understand that any coverage I have under the other plan will be taken into account in determining the amount of benefit payable under the Health and Dental Plan of Lutheran Church–Canada. The benefits under the Plan will be coordinated with the benefits of the other plan.

_____ _____
Signature Date (Month/Day/Year)