Member :
Trade Name: ELECTRICAL WKRS HLTH & WELFARE
Patient Name:

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OTHER INSURANCE INQUIRY

1. Is anyone in the family covered by ANOTHER Health Insurance Plan, Group Plan, or Government Plan, including Medicare or any other federal or state program?

___ Yes. Effective Date: ___/___/___ (Complete Questions 2-7)

___ No. Termination Date:___/___/___ (Complete Questions 2-7 for any coverage held within the last 12 months)
___ No. No Other Coverage (Please Complete #7)

2. Please provide the following information for the primary person (Employee) covered by the Other Plan:
Name: _____ Date of Birth: _____
Social Security # _____ Local Union # _____
Active: Yes ___ No ___ If Yes, Hire date: _____

Retired: Yes ___ No ___ If Yes, Retirement Date: _____

3. Name of employer or organization providing other coverage: _____
_____
Is this a group or individual plan? _____
Group or Plan number: _____

4. Other insurance Plan name: _____
Address & Phone #: _____

5. Is there MEDICAL coverage? Yes ___ No ___
Is there DENTAL coverage? Yes ___ No ___
Is there VISION coverage? Yes ___ No ___

6. Is there dependent coverage? Yes ___ No ___ If Yes, which dependents are covered: _____

I HEREBY CERITFY, TO THE BEST OF MY KNOWLEDGE, THAT THE FOREGOING STATEMENTS ARE TRUE, CORRECT AND COMPLETE.

7. _____ _____
MEMBER SIGNATURE DATE

ANY PERSON MAKING A WILLFUL MISREPRESENTATION IN COMPLETING THIS FORM SHALL BE LIABLE TO THE PLAN FOR ANY LOSS TO THE PLAN RESULTING FROM MISREPRESENTATION.

NOTE: If we do not receive this information in 30 days, we will assume you have other coverage, and that the other carrier has paid the bill in full.