Trade Name: LABORERS HEALTH & WELFARE Member Alt ID #: _____
Member Name: _____Patient Name:_____

OTHER INSURANCE INQUIRY

(Completed Annually for each family member)

Are you or anyone in the family covered by ***ANY OTHER*** health insurance plan, group plan, government plan, including Medicare or any other federal or state program?

☐ **NO** If No, please complete Section 2, sign, date, and return this questionnaire to the Trust Fund.

☐ **YES** If Yes, please complete all the fields in Sections 1 that pertain to the persons(s) that has the other coverage, sign Section 2, and return to the Trust Fund.

If you had any coverage within the last 12 months, please complete Sections 1 and 2.

SECTION 1 IF THIS DOES NOT APPLY, SKIP TO SECTION 2.

Other Insurance Policyholder's Name: _____

Policyholder's Date of Birth: _____ ID# _____

Effective Date of Other Insurance: _____ If Cancelled, Termination Date: _____

Local Union #: _____Active: Yes ☐ No ☐ If Yes, hire date: _____

Is the policyholder retired? _____ If Yes, retirement date: _____

Name of employer or organization providing the other coverage _____

Is this a group or individual plan? _____Group or Plan # _____

Other insurance carrier's name: _____

Address and Phone #: _____

Is there Medical coverage? _____ Dental coverage? _____ Vision coverage? _____

Is there Dependent coverage? _____ Name(s) of Dependents covered by the other insurance plan:

_____

SECTION 2

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

OUR MEMBERS SIGNATURE:_____

DATE SIGNED

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.