ILWU-PMA Welfare Plan
Other Insurance Verification Form

Return before November 25, 2016 - FAX #415-749-1400

PART A: YOUR INFORMATION

LAST NAME	FIRST NAME	M.I.	Participant ID	BIRTHDATE	
HOME ADDRESS			CITY	STATE	ZIP CODE
TELEPHONE	MARITAL STATUS ☐ MARRIED ☐ DIVORCED ☐ WIDOW		LANGUAGE PREFERENCE ☐ English ☐ Spanish ☐ Other _____	E-MAIL ADDRESS	

PART B: YOUR DEPENDENT SPOUSE INFORMATION. COMPLETE THIS SECTION FOR YOUR ELIGIBLE SPOUSE.

LAST NAME OF SPOUSE	FIRST NAME OF SPOUSE	M.I.	SOCIAL SECURITY NO.	BIRTHDATE	SEX (M/F)

Is your spouse employed? ☐ **NO** ☐ **YES** – Please complete Section 1 below.

Is your spouse a retiree? ☐ **NO** ☐ **YES** – If YES, is insurance offered through retirement? ☐ **NO** ☐ **YES** complete Section 2a below.

Is your spouse covered by Medicare or Medicaid? ☐ **NO** ☐ **YES** – by ☐ Medicare ☐ Medicaid, complete Section 2a below.

Section 1. IF YES, please indicate:

1. Employer's Name: _____

2. Is your spouse covered by his/her employer's Health Plan? ☐ **YES** - Please complete Section 2a.

Section 2. Spouse other insurance information:

2a. If YES, please indicate:

Other Insurance Company's Name: _____

Address: _____

Phone No: _____

Policy Number: _____ Effective Date: _____

Insurance type: ☐ Single ☐ Family **Coverage Type:** ☐ Medical ☐ Dental

(Check all that apply)

PART C: YOUR DEPENDENT CHILDREN INFORMATION. ARE ANY OF YOUR DEPENDENT CHILDREN INSURED UNDER ANY OTHER GROUP MEDICAL OR DENTAL INSURANCE – (INCLUDING STUDENT, ACCIDENT, OR GOVERNMENT PLAN)? IF YES, COMPLETE THE NEXT LINES

Dependent Children (for more children use back of form)	**Dependent SSN**	**Coverage offered by** (Name of Non-ILWU-PMA Parent, if applicable)	**Insurance Name**	**Policy Number and Effective Date**

CONSENT INFORMATION

By my signature below, I acknowledge that the ILWU-PMA Plan and its authorized agents may use and disclose health information for purposes related to evaluating, processing, and reviewing my claims or my dependent's claims, and I consent to the disclosure of information requested by the ILWU-PMA Welfare Plan by any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policy holder, employer or benefit plan administrator.

I hereby certify that all information provided on this form is accurate and complete to the best of my knowledge.

_____ _____

ILWU-PMA Plan Covered Employee Signature **Date**

RETURN FORM TO: ILWU-PMA Benefit Plans, 1188 Franklin Street, Suite 101 San Francisco, CA 94109

October 2016