IBEW 292 Health Care Plan

OTHER INSURANCE QUESTIONNAIRE

IBEW 292 Member: _____ ID#: XZ

Do (did) you or your participating dependents have other Medical, Pharmacy, Dental, Vision, Medicare or Medicaid coverage?

❑ Yes ❑ No

Please complete and return the form to our office immediately as we are unable to process claims until this information is received.

OTHER INSURANCE INFORMATION (NON-MEDICARE) ******Please enclose a copy of the other insurance ID card ******

Policyholder's Name: _____ Relationship to IBEW292 Mbr: _____

Policyholder's Date of Birth: _____ ID#: _____ Group#: _____

Original Effective Date: _____ Policy Term Date (*if applicable): _____

**Please provide a copy of your Certificate of Termination*

Policy Covers: ❑ Medical ❑ Pharmacy ❑ Dental ❑ Vision ❑ HSA

Name of Other Insurance Company: _____ Customer Service Ph#: _____

Name of Employer: _____

Is this a Medical Assistance plan sponsored by the state or county? ❑ Yes ❑ No

Please list those covered under the other insurance policy described above. Use additional forms if necessary.

First Name	Last Name	Relationship	Effective Date	Term Date

Is there legal documentation stating who is responsible for carrying the healthcare coverage for you or your dependents?

❑ Yes ❑ No ***If yes, legal documents must accompany the form stating who is responsible for carrying healthcare coverage.***

Name of Responsible Party: _____

Do (did) you or your participating dependents have Medicare coverage? ❑ Yes ❑ No

Name(s): _____

I hereby certify that the above statements are true and complete the best of my knowledge and belief. I understand that if I intentionally falsify or fail to give any of the information requested on this form, claims may be denied and I may be subject to litigation by the Fund. I also understand that I must notify the Fund of any changes in the above information within 30 days of the change.

Signature: _____ Date: _____