Laborers Health and Welfare Trust Fund for Northern California
220 Campus Lane, Fairfield, CA 94534-1498 • Telephone: (707) 864-2800 • Toll Free: 1-(800) 244-4530

Other Insurance Inquiry

(Doc. 644)

IMPORTANT

Please complete this form in full and return it to the Fund Office promptly. No benefits can be released under the Plan until you have provided the information below.

NAME OF PARTICIPANT	SSN

NAME OF PATIENT

DO YOU, YOUR SPOUSE, OR ANY DEPENDENT CHILDREN HAVE MEDICAL, DENTAL, PRESCRIPTION DRUG, AND/OR VISION CARE COVERAGE THROUGH ANOTHER EMPLOYER?

☐ YES ➢ COMPLETE THE BALANCE OF THIS FORM ☐ NO ➢ SIGN THE BOTTOM OF THIS FORM AND RETURN IT TO THE FUND OFFICE

PROVIDE INFORMATION REGARDING EMPLOYER PROVIDING BENEFITS

NAME OF EMPLOYER

ADDRESS OF EMPLOYER

TYPE OF BENEFITS PROVIDED	POLICY NUMBER	EFFECTIVE DATE	TERMINATION DATE	DEPENDENT COVERAGE
NAME & ADDRESS OF MEDICAL INSURANCE				☐ YES ☐ NO
NAME & ADDRESS OF DENTAL INSURANCE				☐ YES ☐ NO
NAME & ADDRESS OF PRESCRIPTION DRUG PLAN				☐ YES ☐ NO
NAME & ADDRESS OF VISION CARE PLAN				☐ YES ☐ NO

PROVIDE INFORMATION REGARDING INSURED

FULL NAME

SOCIAL SECURITY NO.	RELATIONSHIP TO LABORER

I hereby certify under penalty of perjury under the laws of the state in which I reside that the foregoing information is true, correct, and complete to the best of my knowledge.

Participant's Signature _____ Date signed _____