Carpenters Health and Security Plan of Western Washington

PO Box 1929 Seattle, WA 98111-1929

Other Insurance Inquiry

Instructions

The Carpenters Health and Security Plan contains a "coordination of benefits" provision which means this plan coordinates the payment of benefits with any other plan you or a dependent may be covered under. To accurately process your claims, the following information is required. Additional forms are available on the Carpenters Trusts website: www.ctww.org. ***An immediate response to this inquiry is required before your claims can be processed.***

Participant _____ **Social Security Number** _____

Other Insurance Information

While covered under the Carpenters Health and Security Plan, have you or any of your dependents been covered by another plan?

Medical Plan? ☐ Yes ☐ No Prescription Plan? ☐ Yes ☐ No

If you answered "no" to both plans, please sign and date this form and return it to Carpenters Trusts as soon as possible. You may also fax this form to: (206) 441-5839.

If you answered "yes" to one or both plans, please provide the following information from your other plan's member identification card and return this form to Carpenters Trusts as soon as possible. You may also fax this form to: (206) 441-5839.

Name of the other insurance company _____

Customer service department telephone number _____

Insured's name _____

Insured's date of birth _____

Insured's member identification number _____

Divorce Decree / Court Order

Is there a divorce decree / court order / parenting plan that requires one or both parents to provide health insurance for any of your covered dependents? ☐ Yes ☐ No. If "yes," a copy of that document is required by Carpenters Trusts. It will only be used for claims processing. If one was previously provided, you do not need to send it again.

Please list the person(s) required to provide health insurance per the divorce decree / court order / parenting plan?

First Name	Last Name
_____	_____
_____	_____

Please name the person with primary physical custody of dependent? _____

(over, please)

Medicare

If you or one of your dependents are eligible for Medicare, please provide the required information below exactly as it appears on the Medicare card or include a copy of the Medicare card(s) with this form.

Name of eligible person _____ Medicare HIC# _____

Effective date(s) Part A ____ / ____ / ____ Part B ____ /____ / ____ Part D ____ / ____ / ____

Name of eligible person _____ Medicare HIC# _____

Effective date(s) Part A ____ / ____ / ____ Part B ____ /____ / ____ Part D ____ / ____ / ____

Participant's Signature

Signature: _____ Date: _____