OTHER INSURANCE INQUIRY

Please complete and return this form, if you, your spouse, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage.

General Information:

Member's Name: _____

Name of Other Insured Person: _____

Other Insured Person Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Other Insurance Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Insurance Co. Phone #: (_____)_____

Policy/Group Number: _____

Effective date of coverage: _____ Is insurance active: _____

Termination date if applicable: _____

Coverage is (circle) Single Family

Children are covered until age: _____

Type of coverage (circle all that apply) Medical Dental Vision

List covered dependants: _____

_____

_____

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

_____ _____

Member Signature **Date**