NORTHWEST LABORERS-EMPLOYERS HEALTH & SECURITY TRUST
PO BOX 91002 ● SEATTLE, WA 98111-9102
206.282.3600 ● 1.800.826.2102

OTHER COVERAGE STATEMENT

Due to auditing requirements, we periodically require updated information. Please complete and return this form with the requested information and submit to the Trust Office at the address above as soon as possible. Please remember to sign and date this form or it will be considered incomplete and returned to you. If additional space is needed, please write on the back of this form. Thank you in advance for your cooperation.

Date: _____ Participant Name: _____

Participant ID#: _____
Example: TSTP12345678

☐ ***Check this box and sign/return this form if the Other Insurance Coverage information has not changed for you and your dependent(s) from the year before. You may also contact the Customer Service Department at the number above to provide that update.***

1. Are you or any other covered dependent(s) covered by any other insurance plan, including Medicare? ☐ YES ☐ NO

   If YES, please provide information about the other plan:

   Name of Insurance Company or Health Plan _____

   Address/Phone Number _____

   Type of Insurance: ☐ Group ☐ Individual ☐ Retiree ☐ Cobra ☐ Medicare ☐ Medicaid

   Employee/Subscriber Name _____

   Employee/Subscriber ID# & Date of Birth _____

   Group/Plan Number & Effective Date _____

   Family members who are covered under this plan _____

   Plan coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

   Note: If your previous Other Insurance coverage has termed in the past year for you or any of your dependents, please provide the termination date. _____

2. ***To be completed only if applicable:*** If a dependent is a child of divorced or legally separated parents, please (a) complete the information below and (b) provide a copy of the Divorce Decree and/or Parenting Plan. *If this information has already been submitted to the Trust Office, please disregard this request.*

Dependent Child's Full Name	Biological Mother's Full Name & Date of Birth	Biological Father's Full Name & Date of Birth
(1) _____	_____	_____
(2) _____	_____	_____

   If dependent is a child of parents who have never married, please advise who has custody and financial responsibility:

   _____

I certify that the above is true, correct and complete. I also hereby authorize any Employer, Insurance Company, Medical prepayment plan, services organization, Physician, Practitioner or other person; hospital including Veteran's Administration or other institution to release to or obtain from my Benefits Administrator any medical or payment information that may be required to establish the validity of my claims. I further authorize said company, person, or organization to disclose any personal claim information required for medical case study or review. A photocopy of this authorization shall be considered as effective and valid as the original.

Member Signature: _____ Date: _____

Any person who knowingly and with intent to defraud or deceive any health plan, files a statement of claim obtaining any materially false, incomplete, or misleading information is guilty of a crime and may be liable for substantial civil penalties.