Other Insurance Questionnaire

St. Louis – Kansas City Carpenters Regional Health Plan
1419 Hampton Ave, St. Louis, MO 63139
Phone: (314) 644-4802 | Toll-Free: (877) 232-3863 | Fax: (314) 678-1110
Email: benefits@laborfunds.org | Website: laborfunds.org

A. Covered Individual Information

Covered Individual Legal Last Name	Covered Individual Legal First Name	Cov Ind MI	Cov Ind ID Number

Please provide the following information:

Does the above referenced individual have other insurance? ☐ Yes ☐ No

If No, please sign and date this form and return this form to our office at the address or fax number listed above.

NOTE: If the above referenced member/dependent previously had other insurance coverage that has recently terminated, a Certificate of Credible Coverage (COCC) from the other insurance carrier is required in order for claims to be paid correctly. Please include a copy of the COCC with this form as proof of termination from the other insurance carrier.

If Yes, please answer the following:

Does this person carry coverage on dependents? ☐ Yes ☐ No

If No, please complete Section B below for yourself, then sign and date this form and return it to our office at the address/fax listed above, or

If Yes, list names of all dependents and complete Section B below.

B. Other Insurance Information

Other Insurance Company Name	Policy Holder's Name	Relationship to Dependent(s)

Policy Holder's Date of Birth

Dependents covered under plan (if applicable):

1 _____ 2 _____

3 _____ 4 _____

If more than 4 dependents covered under this policy holder, please attach list to this page.

Dependent Effective Date – ***REQUIRED FOR PROMPT CLAIMS PAYMENT***	Coverage Includes: ☐ Medical ☐ Dental ☐ Vision ☐ Prescription

C. Signature

I hereby declare under penalty of perjury that the information on this form is correct and complete to the best of my knowledge. Upon request by the Plan, I agree to obtain and furnish a copy of any divorce decree, support order, or other relevant documents. I understand that if any incorrect or misleading information on this form results in a loss to the Plan, the Plan is entitled to recover the amount of such a loss from me or by withholding from my future benefits.

Covered Individual Signature (REQUIRED) **Date**