Other Insurance Questionnaire

Mid-America Carpenters Regional Council Health Fund (Fund)
St. Louis-Kansas City Southern Region
1419 Hampton Avenue, St. Louis, MO 63139
Phone: (314) 644-4802, option 1 | Fax: (314) 678-1110 | Email: benefits@laborfunds.org

SECTION 1: COVERED INDIVIDUAL INFORMATION

Covered Individual Legal Last Name	Covered Individual Legal First Name	Covered Individual Legal Middle Name	Covered Individual SSN

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 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 Covered Individual carry coverage on dependents? ☐ Yes ☐ No

If No, please complete Section 2 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 2 below.

SECTION 2: OTHER INSURANCE INFORMATION

Other Insurance Company Name	Policyholder Name	Relationship to Policyholder

Policyholder's Date of Birth	Dependents covered under the Fund (if applicable):	
	1. _____ 2. _____	If more than 6 dependents covered under this policy holder, please attach list to this page.
	3. _____ 4. _____	
	5. _____ 6. _____	

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

SECTION 3: AUTHORIZATION

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 Fund, 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 Fund, the Fund is entitled to recover the amount of such a loss from me or by withholding from my future benefits.

X _____ _____

Covered Individual Signature **Date**

Submit completed Other Insurance Questionnaire with copies of all required documents:

- **Upload** securely to the Member Portal: **laborfunds.org/member-portal**
- By **mail** to the address at the top of this Form, Attn: Participant Services
- By **fax** to the fax number at the top of this form