Cement Masons Health & Welfare Trust Fund for Northern California
4160 Dublin Blvd. Suite 100, Dublin, CA 94568
Telephone: (707) 864-3300 • TOLL FREE (888) 245-5005 • FAX (925) 833-7301
norcalcementmasons.org

Dear Participant,

Information has been received indicating that you and/or your dependent(s) may be eligible under another insurance plan. In order to determine the primary carrier for your benefits, please answer the questions below. **All claims will be pending your reply to this questionnaire.** For further information on benefit coordination, please refer to your Health & Welfare SPD (pg.78). Please return this form as soon as possible.

Today's Date: _____

Member's Name: _____ ID#: _____

Is or was there other coverage for you or your dependent(s) other than coverage through No CA Cement Masons within the last 2 years? ☐ No ☐ Yes (if yes fill out **EACH SECTION** below)

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1. Subscriber for other insurance: _____

SSN (for above subscriber): _____ D.O.B: _____

Employer Name: _____

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2. Medical Insurance Name: _____ Policy/ID#: _____

Insurance's Phone#: _____Insurance's address: _____

_____

Effective Date: _____ Termination Date (if applicable): _____

List each person covered under the above plan and their relationship to the subscriber:

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

_____ _____
(Name) (Relationship)

***If more room is needed, please use an additional page*

(Continued on Reverse Side)

3. Plan Type (choose one for each)

a) The subscriber is: ☐ Active Employee ☐ Retired ☐ COBRA ☐ Other _____

b) Medical plan is provided through: ☐ Employer ☐ Private/Individual ☐ State/Federal

c) The medical plan is an: ☐ HMO ☐ PPO ☐ Other: _____

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4. Is there a legal document that assigns primary health care coverage? ☐ Yes ☐ No

(Please ensure our office has a copy of these legal documents on file)

If yes, what is the relationship of the party with decreed responsibility? _____

5. Who has custody of the dependent child(ren)? _____

_____

Please include a copy of the front & back of the insurance card that the above information pertains to

I understand that it is illegal, and a felony in some states for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an enrollment request containing any false, incomplete, or misleading information. In some states, anyone found guilty of insurance fraud is subject to fines, confinement in prison, and/or denial of insurance benefits.

Signature: _____ Date: _____