IBEW LOCAL UNION No. 212 HEALTH AND WELFARE PLAN
2023 OTHER COVERAGE QUESTIONNAIRE FORM

RESPONSE DUE BY DECEMBER 31, 2022
NO RESPONSE COULD RESULT IN SUSPENION OF COVERAGE AND DENIAL OF 2023 CLAIMS

PARTICIPANT NAME: ______________________________________ SSN: ____________________________

☐ **CHECK THIS BOX IF THERE HAVE BEEN NO FAMILY CHANGES OR CHANGES TO OTHER ADDITIONAL INSURANCE SINCE JANUARY 1, 2022. (IF CHECKED, YOU MAY SKIP TO THE BACK OF THE FORM, SIGN AND RETURN. IF LEFT UNCHECKED, PLEASE FILL OUT THE BELOW FORM ACCORDINGLY.)**

A. SOCIAL SECURITY AND MEDICARE NUMBERS (IF ISSUED) ARE REQUIRED DUE TO MEDICARE MANDATORY REPORTING RULES. PLEASE LIST THE SOCIAL SECURITY NUMBERS AND, IF APPLICABLE, THE MEDICAL HICN (HEALTH INSURANCE CLAIM NUMBER) FOR EACH OF YOUR COVERED DEPENDENTS (SPOUSE AND CHILDREN):

NAME: _____________________ SSN: _____________________ MEDICARE HICN: ____________________
NAME: _____________________ SSN: _____________________ MEDICARE HICN: ____________________
NAME: _____________________ SSN: _____________________ MEDICARE HICN: ____________________
(IF ADDITIONAL SPACE IS NEEDED, PLEASE WRITE ON THE BACK OF THIS FORM.)

B. MARRIED ___ SINGLE ___ DIVORCED ___ WIDOWED ___ (CHECK ONE)

IF MARRIED: SPOUSE'S NAME ___________________________ SSN: _____________________
DATE OF BIRTH ____/____/______

OTHER INSURANCE CARRIER NAME: ____________________ POLICY NUMBER: ______________________
ADDRESS: ____
PHONE: ______________________ NAME OF POLICYHOLDER: ______________________
EFFECTIVE DATE: ______________________ TERMINATION DATE: ______________________
DOES THIS PLAN COVER ANY DEPENDENTS? YES___ NO___

PLEASE LIST ALL DEPENDENTS THAT ARE COVERED UNDER YOUR SPOUSE'S PLAN: (IF ADDITIONAL SPACE IS NEEDED, PLEASE USE BACK OF FORM.) TYPE OF COVERAGE (MARK "X" IF YES):

FULL NAME	DATE OF BIRTH	MEDICAL	DENTAL	RX	ORTHO	VISION
___________________	___/___/_____	_________	_________	_________	_________	_________
___________________	___/___/_____	_________	_________	_________	_________	_________
___________________	___/___/_____	_________	_________	_________	_________	_________

IF DEPENDENT CHILDREN ARE COVERED UNDER DIVORCE OR COURT ORDER, PLEASE INCLUDE A COPY OF THE COURT ORDER, QMSCO OR DIVORCE DECREE WITH THIS FORM.

IBEW LOCAL UNION No. 212 HEALTH AND WELFARE PLAN
2023 OTHER COVERAGE QUESTIONNAIRE FORM

C. IF MEDICARE COVERS YOU, YOUR SPOUSE OR ANY OTHER FMAILY MEMBERS, PLEASE COMPLETE BELOW:

NAME: ____________________ EFFECTIVE DATE: _____ PART A__PART B__AGE 65__DISABLED__ESRD__
NAME: ____________________ EFFECTIVE DATE: _____ PART A__PART B__AGE 65__DISABLED__ESRD__

HAVE YOU ELECTED MEDICARE PART D PRESCRIPTION COVERAGE? YES ___ NO ___
EFFECTIVE DATE: _________________
PLEASE SUBMIT A COPY OF YOUR MEDICATE CARD(S).

PLEASE SIGN, DATE AND RETURN THE FORM TO THE FOLLOWING ADDRESS BY DECEMBER 31, 2022:
IBEW LOCAL UNION No. 212 HEALTH AND WELFARE FUND
c/o ZENITH AMERICAN SOLUTIONS, INC.
5420 WEST SOUTHERN AVE, SUITE 407
INDIANAPOLIS, IN 46241
or Fax To: 513-906-4949

AUTHORIZATION TO RELEASE INFORMATION: THE ABOVE ANSWERS ARE TRUE AND COMPLETE ACCORDING TO THE BEST OF MY KNOWLEDGE AND BELIEF. I HEREBY AUTHORIZE ANY EMPLOYER, INSURANCE COMPANY, MEDICAL PREPAYMENT PLAN, SERVICE ORGANIZATION, PHYSICIAN, PRACTITIONER OR OTHER PERSON: ANY 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.

EMPLOYEE SIGNATURE ______________________________________ DATE _________________

SPOUSE SIGNATURE ____ DATE _________________

THIS FORM IS TO UPDATE OTHER COVERAGE INFORMATION ONLY. WHILE IT REQUESTS DEPENDENT INFORMATION, THERE ARE ADDITIONAL FORMS THAT WILL NEED TO BE COMPLETED IF YOU WOULD LIKE TO ADD OR REMOVE A DEPENDENT. PLEASE CONTACT THE FUND OFFICE AT 513-861-4800 SO THAT A TRUST FUND QUESTIONNAIRE CAN BE MAILED TO YOUR ATTENTION AND SENT BACK WITH THE APPROPRIATE REQUIRED DOCUMENTATION.