Other Insurance Questionnaire

Mid-America Carpenters Regional Council Health Fund (Fund)
Northern Illinois Region
12 E. Erie St, Chicago, IL 60611
Phone: (312) 787-9455, option 3 | Fax: (312) 951-1515 | Email: submit@macbenefits.org

SECTION 1: COVERED INDIVIDUAL INFORMATION

Covered Individual Legal Last Name	Covered Individual Legal First Name	Covered Individual Legal Middle Name	Covered Individual SSN
Participant Legal Last Name	**Participant Legal First Name**	**Participant Legal Middle Name**	**Participant SSN / UID**

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): If more than 6 dependents covered under this policy holder, please attach list to this page.
Policy Number	1. _____ 2. _____
Group Number	3. _____ 4. _____
	5. _____ 6. _____

Dependent Effective Date – REQUIRED FOR PROMPT CLAIMS PAYMENT	Coverage Includes: ☐ Medical ☐ Medicare/Tricare

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:

- **MAIL or DROP-OFF**: 12 E. Erie, St., Chicago, IL 60611 or 4979 Indiana Ave, Lisle, IL 60532
- **EMAIL**: submit@macbenefits.org
- **FAX**: (312) 951-1515