OTHER INSURANCE QUESTIONNAIRE

GREATER KANSAS CITY LABORERS WELFARE FUND
6405 Metcalf, Suite 200 • Overland Park, Kansas 66202
(913) 236-5490 • Fax: (913) 236-5499

The medical coverage with the Greater Kansas City Laborers Welfare Fund contains a Coordination of Benefits Provision. Claims for you or your dependents may be delayed until this Other Insurance Questionnaire has been fully completed, signed by both the Member and Spouse and returned to the Fund Office.

SECTION A. - MEMBER INFORMATION – PLEASE PRINT CLEARLY IN INK

LAST NAME	FIRST NAME	MIDDLE NAME	ID NUMBER

DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED, LIST DATE OF MARRIAGE	SOCIAL SECURITY NUMBER

HOME ADDRESS	CITY	STATE	ZIP

HOME PHONE	CELL PHONE

DO YOU HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO	☐ MEDICAL ☐ DENTAL POLICY TYPE ☐ VISION ☐ ACTIVE ☐ RETIREE ☐ COBRA	EFFECTIVE DATE OF OTHER INSURANCE COVERAGE TERMINATION DATE OF OTHER INSURANCE COVERAGE

NAME OF PLAN	PHONE NUMBER OF PLAN

ARE YOU ELIGIBILE FOR MEDICARE? ☐ YES ☐ NO IF YES, IS IT DUE TO ☐ END-STAGE RENAL DISEASE AND / OR ☐ DISABILITY

IF YES, WHEN?	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE	PART D EFFECTIVE DATE

NOTE: UNLESS YOU HAVE ALREADY PROVIDED DOCUMENTATION TO THE FUND OFFICE, YOU WILL NEED TO PROVIDE A COPY OF YOUR MARRIAGE CERTIFICATE

SECTION B. SPOUSE INFORMATION – (IF APPLICABLE)

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER

DATE OF BIRTH	HOME ADDRESS	CITY	STATE	ZIP	HOME PHONE

DO YOU HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO	☐ MEDICAL ☐ DENTAL POLICY TYPE ☐ VISION ☐ ACTIVE ☐ RETIREE ☐ COBRA	EFFECTIVE DATE OF OTHER INSURANCE COVERAGE TERMINATION DATE OF OTHER INSURANCE COVERAGE

NAME OF PLAN	PHONE NUMBER OF PLAN

ARE YOU ELIGIBILE FOR MEDICARE? ☐ YES ☐ NO IF YES, IS IT DUE TO ☐ END-STAGE RENAL DISEASE AND / OR ☐ DISABILITY

IF YES, WHEN?	PART A EFFECTIVE DATE	PART B EFFECTIVE DATE	PART D EFFECTIVE DATE

NOTE: UNLESS YOU HAVE ALREADY PROVIDED DOCUMENTATION TO THE FUND OFFICE, YOU WILL NEED TO PROVIDE A COPY OF THE CHILD'S BIRTH CERTIFICATE AND/OR A COPY OF THE LEGAL ORDER TO PROVIDE MEDICAL COVERAGE TO THE CHILD

SECTION C. DEPENDENT # 1 INFORMATION – (IF APPLICABLE)

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER

DATE OF BIRTH	HOME ADDRESS	CITY	STATE	ZIP	HOME PHONE

MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED, LIST DATE OF MARRIAGE

YOUR RELATIONSHIP TO CHILD: ☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ STEP CHILD ☐ OTHER _____

IS THE DEPENDENT COVERED THROUGH OTHER INSURANCE COVERAGE? ☐ YES ☐ NO SUBSCRIBER NAME:_____ IF YES, COVERAGE TYPE ☐ MEDICAL ☐ DENTAL ☐ VISION POLICY NUMBER:_____	EFFECTIVE DATE OF OTHER INSURANCE COVERAGE TERMINATION DATE OF OTHER INSURANCE COVERAGE

NAME OF PLAN	PHONE NUMBER OF PLAN

IS DEPENDENT MARRIED? ☐ YES ☐ NO IF YES, NAME OF CHILD'S SPOUSE

DEPENDENT #2 INFORMATION – (IF APPLICABLE)

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER

DATE OF BIRTH	HOME ADDRESS	CITY	STATE	ZIP	HOME PHONE

MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED, LIST DATE OF MARRIAGE

YOUR RELATIONSHIP TO CHILD: ☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ STEP CHILD ☐ OTHER _____

IS THE DEPENDENT COVERED THROUGH OTHER INSURANCE COVERAGE?	EFFECTIVE DATE OF OTHER INSURANCE COVERAGE
☐ YES ☐ NO SUBSCRIBER NAME: _____	
IF YES, COVERAGE TYPE ☐ MEDICAL ☐ DENTAL ☐ VISION	TERMINATION DATE OF OTHER INSURANCE COVERAGE
POLICY NUMBER: _____	
NAME OF PLAN	PHONE NUMBER OF PLAN

IS DEPENDENT MARRIED? ☐ YES ☐ NO IF YES, NAME OF CHILD'S SPOUSE

DEPENDENT #3 INFORMATION – (IF APPLICABLE)

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER

DATE OF BIRTH	HOME ADDRESS	CITY	STATE	ZIP	HOME PHONE

MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED, LIST DATE OF MARRIAGE

YOUR RELATIONSHIP TO CHILD: ☐ NATURAL CHILD ☐ ADOPTED CHILD ☐ STEP CHILD ☐ OTHER _____

IS THE DEPENDENT COVERED THROUGH OTHER INSURANCE COVERAGE?	EFFECTIVE DATE OF OTHER INSURANCE COVERAGE
☐ YES ☐ NO SUBSCRIBER NAME: _____	
IF YES, COVERAGE TYPE ☐ MEDICAL ☐ DENTAL ☐ VISION	TERMINATION DATE OF OTHER INSURANCE COVERAGE
POLICY NUMBER: _____	
NAME OF PLAN	PHONE NUMBER OF PLAN

IS DEPENDENT MARRIED? ☐ YES ☐ NO IF YES, NAME OF CHILD'S SPOUSE

SECTION D. CERTIFICATION AND SIGNATURE

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO IMMEDIATELY NOTIFY THE FUND OFFICE OF ANY CHANGES IN THE ABOVE INFORMATION. I HEREBY DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. TO ENSURE WE HAVE THE CORRECT NUMBER IN THE EVENT WE NEED TO CONTACT YOU, PLEASE PROVIDE A DAYTIME PHONE NUMBER WHERE YOU CAN BE REACHED BETWEEN 8:00 AM AND 5:00PM, MONDAY THROUGH FRIDAY.

PRINT NAME	DAYTIME PHONE

MEMBER SIGNATURE

PRINT NAME	DAYTIME PHONE

SPOUSE SIGNATURE

PLEASE RETURN THIS FORM AND COPIES OF ALL OTHER INSURANCE CARDS, IF POSSIBLE TO THE FUND OFFICE:

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