FOX VALLEY LABORERS HEALTH AND WELFARE FUND
2371 Bowes Road, Suite 500
Elgin, Illinois 60123-5523
Phone 847-742-0900 • Toll Free 866-828-0900 • Fax 847-742-4430

To: Health and Welfare Participants

Subject: Other Insurance Statement

In order to ensure correct benefit determination, please verify whether other insurance coverage exists for you and your family members. Please complete this form and return it to the Fund Office.

Participant Name:_____ SSN/FVL #:_____

Is any member of your family covered by any other insurance plan or eligible for Medicare?

Name:_____ Relationship:_____ Birthdate:_____ No____Yes __
Name:_____ Relationship:_____ Birthdate:_____ No____Yes __
Name:_____ Relationship:_____ Birthdate:_____ No____Yes __
Name:_____ Relationship:_____ Birthdate:_____ No____Yes __
Name:_____ Relationship:_____ Birthdate:_____ No____Yes __
Name:_____ Relationship:_____ Birthdate:_____ No____Yes __

Please complete the following information for each family member who has or had other insurance. Use additional forms if necessary.

If no, list termination date of the other coverage (if applicable):
Name:_____ Termination Date: _____/_____/_____

If yes, complete the entire form, sign and date below.

Name: _____
Address: _____
Social security number: _____-____-_____ Birthdate: ____/_____/_____

If the other plan is for your spouse, does it cover your dependent children? Yes _____ No _____
If yes, list all family members covered by the other plan:

_____
_____

What type of coverage does the other plan provide? Circle one or more of the following:
Medical Dental Vision Prescription Drugs Other: _____

If any of the above coverage has terminated, list the type of coverage and its termination date:
_____/_____/_____

Name and address of other insurance carrier: _____
_____

Effective date: _____/_____/_____ Group/Plan Number: _____

Primary Insured's Name _____ Insured's Number_____

_____ _____ _____ _____
Participant Signature Date Spouse Signature Date

**PLEASE INCLUDE A COPY OF THE FRONT & BACK OF YOUR INSURANCE AND/OR MEDICARE CARD WHEN YOU RETURN THIS FORM.**

It is fraudulent to fill out this form with information you know to be false or knowingly omit important facts. Criminal and/or civil penalties can result from such an act. If any of the above information is untrue, I agree to reimburse the Fox Valley Laborers Health and Welfare Fund for any money it was induced to pay as a result of the information I provided. Receipt of this form is not a guarantee of eligibility.