ILWU-PMA BENEFIT PLANS /
International Longshore & Warehouse Union —
Pacific Maritime Association
www.benefitplans.org
1188 FRANKLIN STREET • SUITE 101 • SAN FRANCISCO, CALIFORNIA 94109
PHONE (415) 673-8500
FAX (415) 749-1400

ILWU-PMA Pension Plan
ILWU-PMA Welfare Plan
ILWU-PMA Watchmen Pension Plan

October 13, 2017

To: ILWU Longshore, Ship Clerk, Walking Boss/Foreman, and Watchmen Locals

From: Mario Perez, Manager, Welfare Plans

Subject: ILWU-PMA Coastwise Indemnity Plan – Annual Other Insurance Coverage Verification Requirement

The attached letter and form are being mailed out beginning today by the Coastwise Claims Office. In order to better receive and track requests for other insurance information, this is an annual mailing each October to collect the information. The mailing will be sent to all members with dependents, unless all covered family members are Retirees with Medicare as their primary carrier. The mailing will not be sent to members whose spouse is also an employee with ILWU-PMA Welfare coverage. Please encourage members to complete the form and return it timely to avoid future claim processing delays. To assist with the tracking, the forms are being returned to the Benefit Plans Office, who will log and then route the form to the CCO. The documents can be mailed or faxed in.

Attachments

cc: Area Welfare Directors

A copy of this memo can be downloaded at www.benefitplans.org

MP:cy/opeiu29aflcio/MTP – Annual Other Insurance Coverage Verification Requirement - 101317

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109
FAX # 415-749-1400

URGENT - RESPONSE REQUIRED BY 11/13/17

Annual Other Insurance Coverage
Verification Requirement

Dear ILWU-PMA Coastwise Indemnity Plan Participant: October 13, 2017

The Plan is requiring completed Other Insurance Coverage Forms on an annual basis for those members that have covered dependents. Each October you will receive notification requesting the completion of the enclosed Other Insurance Coverage (OIC) form. Completing this annual requirement will make it simpler to expedite claim benefit payments for you and your dependents and avoid requests based on individual claim denials for each family member throughout the year.

Even if you have provided this information earlier this year, you will need to submit the completed enclosed form to avoid any delay in your family's claim benefit payments.

Therefore, you must:

- Complete, sign and return the Other Insurance Coverage Form enclosed by November 13, 2017.

  Fax to: #415-749-1400 <u>OR</u> mail using the enclosed pre-paid addressed envelope.

  If you do not return the form:

- Your dependents' benefit claims for dates of service after December 31, 2017 will be denied until the form is received.

Let us know if you have any questions or need help. You can call our Customer Service Office at (800)955-7376.

ILWU-PMA Welfare Plan
Other Insurance Verification Form

Return before November 13, 2017 - FAX #415-749-1400

You are required to fill this form out and return even if you have no other insurance

PART A: YOUR INFORMATION

LAST NAME	FIRST NAME	M.I.	Welfare ID	BIRTHDATE	
HOME ADDRESS			CITY	STATE	ZIP CODE

TELEPHONE	MARITAL STATUS	
	☐ MARRIED ☐ DIVORCED ☐ WIDOW ☐ SINGLE	**If no changes to last year's information select no changes, sign, date, and return ☐ NO Changes**

PART B: YOUR DEPENDENT SPOUSE INFORMATION. COMPLETE THIS SECTION FOR YOUR ELIGIBLE SPOUSE.

LAST NAME OF SPOUSE	FIRST NAME OF SPOUSE	M.I.	SOCIAL SECURITY NO.	BIRTHDATE	SEX (M/F)

Is your spouse employed? ☐ **NO** ☐ **YES** – Please complete Section 1 below.

Is your spouse a retiree? ☐ **NO** ☐ **YES** – If YES, is insurance offered through retirement? ☐ **NO** ☐ **YES** complete Section 2a below.

Is your spouse covered by Medicare or Medicaid? ☐ **NO** ☐ **YES**– by ☐ Medicare ☐ Medicaid, complete Section 2a below. ☐ Other If YES**,** complete Section 2a below

Section 1. IF YES, please indicate:

1. Spouses' Employers Name: _____

2. Is your spouse covered by his/her employer's Health Plan? ☐ **YES** - Please complete Section 2a. ☐ **NO**

Section 2. Spouse other insurance information:

2a. If YES, please indicate:

Other Insurance Company's Name: _____

Address: _____

Phone No: _____

Policy Number: _____ Effective Date: _____ Term Date: _____

Insurance type: ☐ Single ☐ Family **Coverage Type:** ☐ Medical ☐ Dental

(Check all that apply)

PART C: YOUR DEPENDENT CHILDREN INFORMATION. ARE ANY OF YOUR DEPENDENT CHILDREN INSURED UNDER ANY OTHER GROUP MEDICAL OR DENTAL INSURANCE – (INCLUDING STUDENT, ACCIDENT, OR GOVERNMENT PLAN)? IF YES, COMPLETE THE NEXT LINES.

Dependent Children (for more children use back of form)	**Dependent SSN**	**Coverage offered by** (Name of Non-ILWU-PMA Parent, if applicable)	**Insurance Name**	**Policy Number and Effective Date**

CONSENT INFORMATION

By my signature below, I acknowledge that the ILWU-PMA Plan and its authorized agents may use and disclose health information for purposes related to evaluating, processing, and reviewing my claims or my dependent's claims, and I consent to the disclosure of information requested by the ILWU-PMA Welfare Plan by any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policy holder, employer or benefit plan administrator.

I hereby certify that all information provided on this form is accurate and complete to the best of my knowledge.

_____ _____

ILWU-PMA Plan Covered Employee Signature **Date**

RETURN FORM TO: ILWU-PMA Benefit Plans, 1188 Franklin Street, Suite 101 San Francisco, CA 94109 OR by FAX 415-749-1400