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

December 1, 2020

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

From: Mario Perez, Director of Benefit Plans

Subject: ILWU-PMA Welfare Plan - Coastwise Claims Office
Annual Other Insurance Coverage Verification Requirement

The attached letter and form began mailing by the Coastwise Claims Office. In order to better receive and track requests for other insurance information, this is an annual mailing each year to collect the information. The mailing will be sent to all members. This year, in addition to faxing or mailing the form, members can log in to a secure website to complete and submit the information. Please encourage members to complete the process timely to avoid future claim processing delays. Members with Kaiser are required to complete the process as the CCO processes their chiropractic claims.

Attachments

cc: Area Welfare Directors

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

MP:cy/MTP-CCO Annual OIC Verification Requirement-120120

ILWU-PMA Benefit Plans
1188 Franklin Street, Suite 101
San Francisco, CA 94109
FAX # 415-646-4414

URGENT - RESPONSE REQUIRED

Please complete this form online using the link provided or if you prefer you may return by fax or by mail in the enclosed envelope. If you do not return the enclosed form by December 31, 2020, claims for your dependents will be denied until this form is received.

Dear ILWU-PMA Welfare Plan Participant:

The Plan requires ALL members with covered dependents to complete an Other Insurance Coverage Form on an annual basis. Although you may be on Medicare or dual covered under the ILWU-PMA Welfare Plan, you are required to complete this form in order to process your medical claims correctly.

Additionally, there are a few other groups of people who need to provide information about other insurance, these include:

- **Surviving Spouses, Surviving Children and Non-Medicare Retirees**

People in these groups may have additional insurance which would be considered primary to their ILWU-PMA Welfare Plan coverage. We need to know the details of this insurance in order to properly coordinate benefits. **Please include information on your primary insurance in part C of the enclosed form (marked for Dependent Spouse).**

Even if you have provided this information earlier this year, you are still required to submit the enclosed form to avoid any delay in your family's medical claims.

In order to provide up to date information to the Plan see the instructions below:

The quickest most efficient way to respond is by going to the link below, logging in to the secure site and completing the form online. (The secure site is called Participant Edge, Zenith American Solutions Portals.)

https://edge.zenith-american.com/

(Do NOT use SSN to register – enter your Welfare ID in the Alternate ID field)

***Welfare ID is found on your Coastwise Medical Card under Participant ID and on the enclosed OIC form after your name**

If you do not have access to a computer you may also fill out the enclosed form and send back by:

Fax to (415) 646-4414 OR mail using the enclosed pre-paid addressed envelope.

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

ILWU-PMA
Benefit Plans

ILWU-PMA WELFARE PLAN – OTHER INSURANCE VERIFICATION FORM

Complete, Sign and Return Before **December 31, 2020**

YOU ARE REQUIRED TO FILL OUT THIS FORM AND RETURN IT. IF YOU DO NOT RETURN THIS FORM COMPLETED BY THE DATE INDICATED ABOVE, YOUR SPOUSE'S AND/OR DEPENDENTS' CLAIMS WILL BE DENIED UNTIL THE FORM IS RETURNED.

Part A: Your Information

Legal Last Name:	Legal First Name:	Middle Initial:	Welfare ID:	Date of Birth:	
Home Address:			City:	State:	Zip Code:
Telephone:	Marital Status: ☐ Married ☐ Separated ☐ Widow ☐ Divorce (date _____) ☐ Never Married				

Part B: Your Dependent Spouse Information if applicable.

Complete this section to continue to coverage for your eligible spouse.

Legal Last Name:	Legal First Name:	Middle Initial:	Date of Birth:

1. Is your spouse **employed**? ☐ **NO** ☐ **YES** - *If YES, please complete section C below.*
2. Is your spouse currently employed by ILWU-PMA? ☐ **NO** ☐ **YES** - ***If YES, Reg. # and/or Welfare ID:*** _____ *Proceed to Part D.*
3. Is your spouse a **retiree**? ☐ **NO** ☐ **YES** – Is insurance offered through retirement? ☐ **NO** ☐ **YES** – *If YES, please complete section C below.*
4. Is your spouse covered by **Medicare** or **Medicaid**? ☐ **NO** ☐ **YES** – ☐ Medicare ☐ Medicaid – Please complete Section C below.

Part C: Dependent Spouse Employer's Health Plan Information.

C. If YES to question B1, 3 or 4:

Insurance Name: _____

Address: _____

Policy Number: _____ Effective Date: _____

Insurance type: Check all that apply:

☐ **Employee Only** ☐ **Family** ☐ **Medical** ☐ **Dental** ☐ **Vision**

Part D: Dependent Children Information.

Are your dependents covered by any other group medical, vision, or dental insurance - including student, accident, or government plan? **If YES, complete the table:**

Dependent Children (for more children use back of form)	**Date of Birth**	**Insurance Name and Address**	**Policy Number and Effective Date**	**Coverage Offered By:**	**Type of Coverage Medical/Vision/ Dental**
				☐ Spouse ☐ Other	☐ **M** ☐ **V** ☐ D
				☐ Spouse ☐ Other	☐ **M** ☐ **V** ☐ D
				☐ Spouse ☐ Other	☐ **M** ☐ **V** ☐ D
				☐ Spouse ☐ Other	☐ **M** ☐ **V** ☐ D
				☐ Spouse ☐ Other	☐ **M** ☐ **V** ☐ D

Consent Information

By my signature below, I acknowledge that the ILWU-PMA Coastwise Claims Office 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 Coastwise Claims Office, 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.

This consent will be valid for the entire period of my eligibility and my dependent's eligibility under the Plan. I hereby certify that all information provided on this form is accurate and complete to the best of my knowledge.

✕ _____ _____

ILWU-PMA Covered Employee Signature Date

COMPLETE, SIGN AND RETURN FORM TO: ILWU-PMA Benefit Plans, 1188 Franklin Street, Suite 101, SAN FRANCISCO, CA 94109. FAX: 1-415-646-4414