ILWU-PMA BENEFIT PLANS / International Longshore & Warehouse Union — Pacific Maritime Association www.benefitplans.org
1188 FRANKLIN STREET • SUITE 101 • SAN FRANCISCO, CALIFORNIA 94109
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ILWU-PMA Pension Plan
ILWU-PMA Welfare Plan
ILWU-PMA Watchmen Pension Plan

January 4, 2022

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 will be mailed by the Coastwise Claims Office this week. 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. Members can fax, mail, or log in to a secure website to complete and submit the information. Please encourage members to complete the process timely to avoid future claims 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:rh/opeiu29,afl-cio/MTP_CCO Annual OIC Verification Requirement – 01.04.2022

ILWU-PMA Coastwise Claims Office
PO Box 429101
San Francisco, CA 94142
FAX # 415-646-4414

URGENT - RESPONSE REQUIRED January 4, 2022

<u>Please complete this form online using the link below</u>

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

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 February 11, 2022, claims for your dependents will be denied until this form is received.

Dear ILWU-PMA Welfare Plan Participant:

This 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 the above groups may have additional insurance which could be considered primary to their ILWU-PMA Welfare Plan coverage. In order to properly coordinate benefits, the Coastwise Claims Office must know the details of your additional insurance.

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

In order to provide current information to the Plan please see the instructions below:

The quickest, most efficient way to respond is by going to the link below. Log in to the secure site and complete the form online. The secure site is called <u>Participant Edge, Zenith American Solutions Portals</u> (see link below). By clicking on "Contact Us" within the portal there is an option to upload a completed form or ask questions about this process, in lieu of calling customer service and potentially waiting on hold.

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"**

If you do not have access to a computer, you may complete the enclosed form and send via:

Fax to (415) 646-4414 <u>OR</u> mail using the enclosed pre-paid addressed envelope

If you have any questions or need assistance with this process, please contact the Coastwise Claims Customer Service Office at (800) 955-7376.

ILWU-PMA Benefit Plans

ILWU-PMA WELFARE PLAN – OTHER INSURANCE VERIFICATION FORM

Complete, Sign and Return Before February 11, 2022

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:	Married ☐	Separated ☐	Widowed ☐	Divorced (Date): ☐	Never Married ☐
Do you have other MEDICAL insurance (Private, Medicare, Medicaid, Retiree, etc.)?	Private ☐	Medicare ☐	Medicaid ☐	Retiree ☐	Student ☐
Insurance Co Name:	Phone Number:	Policy Number (ID Number):		Effective Date:	
Do you have a spouse covered under this Plan (If Yes, complete Part B, if No, skip to Part C)				Yes ☐	No ☐

Part B: Dependent Spouse Information

Legal Last Name:	Legal First Name:		Middle Initial:	Date of Birth:		
Does your spouse have other MEDICAL insurance (Private, Medicare, Medicaid, Retiree, Student, ILWU- PMA, etc.)?	ILWU-PMA ☐	Private ☐	Medicare ☐	Medicaid ☐	Retiree ☐	Student ☐
Insurance Co Name:	Phone Number:	Policy Number (ID Number):		Effective Date:		

Part C: Dependent Children Information

Do any of your dependents have other MEDICAL insurance (Private, Medicare, Medicaid, Retiree, Student, ILWU-PMA, etc.)?	ILWU-PMA ☐	Private ☐	Medicare ☐	Medicaid ☐	Retiree ☐	Student ☐

Please complete a line for each dependent child covered under the Plan. If the child has other MEDICAL insurance (Private, Medicare, Medicaid, Student, etc., please add the specific information, if No, write N/A)

Full Name	Date of Birth	Other Insurance Y/N		Insurance Company Name	Insurance Company Phone Number	Policy/Member Number	Effective Date
		Yes ☐	No ☐				
		Yes ☐	No ☐				
		Yes ☐	No ☐				
		Yes ☐	No ☐				
		Yes ☐	No ☐				
		Yes ☐	No ☐				

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