LOCAL 26 IBEW-NECA Joint Trust Funds

Electrical Welfare Trust Fund • Electrical Workers Local No. 26 Pension Trust Fund • Electrical Workers Local No. 26 Individual Account Plan • Local Labor Management Cooperation Committee

Other Insurance Update

If you, your spouse or any eligible dependents have coverage with another company, you are required to tell EWTF this information so that a proper determination can be made as to which company is primary. If you do not file with the correct company, then you may be liable for any overpayments made to your healthcare providers. You **must** answer each question on both pages.

Is this a new address, telephone # or email address? ☐ YES ☐ NO

Part I (Participant Information)

Participant's Last Name	First Name	Middle Initial
Street Address	City & State	Zip Code
Phone Number (include area code) Home Cell	Email Address	
Social Security Number	Date of Birth	Gender M F

Part II (Is there other coverage in addition to EWTF?)

Medicare Coverage	Do you, your spouse or any family members that are on file with EWTF have any Medicare coverage? YES NO (If YES, attach a copy of the front of the card for each person.)
Other Insurance Coverage	Do you, your spouse or any family members that are on file with EWTF have any other group health plan other than EWTF? YES NO (Attach a copy of the front and back of the card for each person)

Part III (Who has Other Coverage) - List all family members including your current spouse on file with EWTF. If they are not employed and do not have other coverage through employment, enter "N/A" in the space provided. If more space is needed continue on a separate piece of paper.

Name	Relationship	Date of Birth	Dependent's SSN	Name of Other Coverage

10003 Derekwood Lane • Suite 130 • Lanham, MD 20706-4811
(301) 731-1050 • fax (301) 731-1065
info@EWTF.org • www.EWTF.org • www.EWTF-WellnessWorks.org

Other Insurance Details

Remember to attach a copy of the front and back of the card for each person.

If these sections are not completed in full, one of two things will occur:

1. spouse and/or dependents coverage may be suspended*

2. any claims received will not be paid until info regarding other insurance coverage is received.

***** This includes eligibility updates to UHC, Caremark & VSP.

Attach a separate piece of paper if more room is needed.

Part IV (Family members listed on Spouse's Coverage)

Spouse's Name	Employer's Telephone Number
Address of Other Insurance Company	Telephone Number

Is this an (check the appropriate plan)	Type of Coverage (check the appropriate coverage)
_____Individual _____Family plan? List the family members on this plan (if applicable)	____ Medical ____ Dental ____ Vision ____ Hospitalization ____ Prescription* ____ Mental Health incl Chemical Dependency ____ All of the above Effective date of coverage: _____ * Is this prescription coverage under Medicare Part D? Y N (circle Y or N)

Part V (Children listed on an X-Spouse's Coverage)

Name of Child(ren)	Name and Telephone Number of Group Health Plan
Whose Policy is it and what is the relationship to the child(ren) Policy #	Type of Coverage (check the appropriate coverage) ____ Medical ____ Dental ____ Vision ____ Hospitalization ____ Prescription ____ Mental Health incl Chem Dep ____ All of the above Effective date of coverage: _____

Ex-spouse's Name	Ex-spouse DOB

Participant Signature (person working under Local 26 jurisdiction)

I certify that the information furnished by me to the Electrical Welfare Trust (EWTF) is accurate and complete and that I am responsible for notifying EWTF of any changes in the status or address of listed dependents. I further understand that I am responsible for benefits paid based upon the information that I have furnished and that furnishing any benefits paid by EWTF based on incorrect information may result in the loss of future benefits and will require repayment of benefits. This is the original document and not a copy.

Signature _____ **Date** _____