737 Bishop Street, Suite 1200
Honolulu, HI 96813

IMPORTANT – REPLY REQUIRED

Request for Other Medical Coverage Information

Dear Hawaii Electricians Member:

To ensure we process your claims appropriately, HWMG and the Hawaii Electricians Health and Welfare Fund are requesting information regarding any other medical insurance coverage you may have. Please complete this form **even if you have no other medical coverage**, and return it to HWMG in the self-addressed stamped envelope provided, or you may fax it to us at **(808) 535-8302**. Thank you for your cooperation!

________________________________ ________________________________
Member Name (please print) Member ID Number (refer to your ID card)

1. Is your spouse employed? Yes________ No________ Not Applicable _______

   If yes, name of employer: ____
   Employer address: ____
   ____

   If yes, does your spouse have medical coverage through his/her employer?

   Yes________ No_________

   If yes:
   Name of carrier: ____
   Group number: ________________ Member number: ___________________
   Type of coverage: Subscriber Only _______ Subscriber+Spouse _______
   Subscriber+Child ______ Family ________

2. Do you and/or your dependents have other medical coverage?

   Yes________ No _________

   If yes, name of the subscriber of the other policy: ______________________________
   Name of carrier: ____
   Group number: ______________________ Member number: _________________
   Type of coverage: Subscriber Only _______ Subscriber+Spouse _______
   Subscriber+Child ______ Family _________

(continued on reverse)

3. If any of your minor dependents are stepchildren, adopted, etc., please describe any additional medical coverage being provided by a natural parent, as established by a Court Decree:

____
____
____

I/We understand that the Fund is relying on this information to determine eligibility for medical benefits for myself and my dependents. I/We understand that it is unlawful for me to make any statements which I/we know is untrue, false or misleading. I/We declare and affirm in good faith and under perjury under Federal and State laws that the information provided herein is true and correct to the best of my knowledge and I/we consent to the provisions stated above on this form which I/we have read and fully understand. I/We also understand that the penalty for committing perjury may be a fine or imprisonment, or both, and may also result in a legal claim against me for recovery or offset of benefits improperly paid to me or my dependents based on the information provided herein.

Signatures:

________________________________ ____________________
Subscriber's Signature Date

________________________________ ____________________
Spouse's Signature Date

Please return this letter and a copy of your other insurance ID card (if any) to expedite the processing of your claims.

If you have any questions, please feel free to contact our Customer Service Center at 941-4622, toll-free at (888) 941-4622 or via e-mail at CustomerService@hwmg.org.