220 S KING STREET, SUITE 1200
HONOLULU, HAWAII 96813

IMPORTANT – REPLY REQUIRED
Request for Other Medical Coverage Information

Dear Hawaii Electricians Health and Welfare Fund 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, feel free to contact our Customer Service Center at 941-4622, toll-free at (888) 941-4622 or CustomerService@hwmg.org.