AFL HOTEL AND RESTAURANT WORKERS HEALTH AND WELFARE TRUST

560 N. Nimitz Highway, Suite 217E ▪ Honolulu, Hawaii 96817-5327
Mailing Address P.O. Box 29939 ▪ Honolulu, Hawaii 96820
Telephone (808) 275-2520 ▪Toll-Free Telephone (844) 808-2520
Facsimile (808) 275-2521
Claims Administrative Office

Dear Participant:

The Board of Trustees has directed the Claims Administrator to verify if you or your dependents have coverage through other Plans. Under the terms of this Plan, the benefits of this Plan and those of the other plans must be coordinated so that the total benefits from all Plans are not greater than the Eligible Charge under this Plan.

Please circle Yes or No below

1. Are you covered under any other group health Plan?	Yes	No
2. Is your spouse (husband/wife) covered under any other group health Plan?	Yes	No
3. Is any eligible dependent child covered under any other group health Plan?	Yes	No

If you circled No to all three questions above, please sign the back of this form near the X and return this letter in the envelope provided.

If you circled Yes, please complete the information requested below for each individual who has other coverage. Please use a separate page if needed:

Spouse Name: _____ Date of birth: _____/_____/_____

Other Plan Name _____

Group or Policy #: _____ Effective date: ____/____/____ Termination date: ____/____/____

Is this plan: Medicare_____ Medicaid/Quest _____ Is this an Active or Retiree_____

Is this Family or Individual Coverage? (Please circle one and submit a *copy* of the other Insurance Card(s)

Please complete the following section for all dependents listed on the plan over 18 years of age.

Name: _____ Relationship_____ Date of birth: _____/_____/_____

Other Plan Name _____

Group or Policy #: _____ Effective date: ____/____/____ Termination date: ____/____/____

Is this plan: Medicare_____ Medicaid/Quest _____

Please submit a *copy* of the other Insurance Card(s)

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Name: _____ Relationship_____Date of birth: _____/_____/_____

Other Plan Name _____

Group or Policy #: _____ Effective date: ____/____/____ Termination date: ____/____/____

Is this plan: Medicare_____ Medicaid/Quest _____

Please submit a *copy* of the other Insurance Card(s)

For children of parents who are separated or divorced. Please use a separate page if needed:

Child's Name:_____ Date of birth:_____/_____/____With whom does the child reside:_____

Child's Name:_____ Date of birth:_____/_____/____With whom does the child reside:_____

Name of parent with custody:_____ Name of step-parent with custody: _____

Other Plan Name: _____ SSN or ID Number_____

Group or Policy #: _____ Effective date: ____/____/____ Termination date: ____/____/____

Is there a court decree that determines financial responsibility for this child? Yes____ No_____

If yes, please attach a copy of this decree.

Person responsible for Dependent Health Care Expenses per divorce decree: _____

IMPORTANT: If you or your dependents previously had other insurance coverage that has been terminated, please include a copy of that plan's notice of termination.

I hereby certify that the foregoing statements are to the best of my knowledge and belief true, correct and complete. If this statement changes in any way, I agree to contact The Trust Fund office immediately.

X_____ _____, 2020
Participant's Signature (Plan Member) Month Day

Any person making a willful misrepresentation in completing this form shall be liable to the Plan for any loss to the Plan resulting from such misrepresentation. Refer to the Handbook of Benefits Section, "Coordination of Benefits" for the specific Plan provision.