Member's Name:

_____

Member's ID:

_____

Patient's Name:

_____

Other Insurance Form

LiUNA!

WISCONSIN LABORERS' HEALTH FUND

Feel the Power

We are in need of additional information to determine benefits. Please complete the information requested below and return it to Wisconsin Laborers' Health Fund with any applicable documents as indicated. If the other insurance has terminated please add that information.

Are you or any other family members covered by any other insurance, Medicare, or COBRA plan
_____ YES _____ NO If Medicare, please provide a copy of the Medicare ID card.

If yes, please complete the following:
Name of other insurance company: _____

Phone number of other insurance company: _____

Employee/Subscriber name & date of birth: _____

Subscriber's identification number: _____

Policy number & effective date: _____

List family members covered by the other plan: _____
_____
_____
_____

Type of coverage (check all that apply):
_____ Medical _____ Dental _____ Vision _____ Prescription

I certify that the above is true and complete to the best of my knowledge. I will reimburse the Plan for any overpayment made to me or on my behalf due to error on this form.

Signature: _____ Date: _____

Thank you for your assistance.
Sincerely
WISCONSIN LABORERS' HEALTH FUND

Please Return One of the Following Ways:

Mail:
Wisconsin Laborers' Health Fund
Attn: Claims
4633 Liuna Way
Deforest, WI 53532

Fax:
(608) 846-3224
Wisconsin Laborers' Health Fund
Attn: Claims

Upload to Website:
Scan document and save to computer as PDF
Visit www.wilbenefits.com
Scroll to "upload document to claims department"
Browse for saved PDF
Upload

Email:
wlclaims@benesys.com
Please Put "Other Insurance Form" as Subject