ILWU-PMA BENEFIT PLANS /

International Longshore & Warehouse Union —
Pacific Maritime Association www.benefitplans.org

PHONE (415) 673-8500 FAX (415) 749-1400

1188 FRANKLIN STREET • SUITE 101 • SAN FRANCISCO, CALIFORNIA 94109

ILWU-PMA Pension Plan ILWU-PMA Welfare Plan ILWU-PMA Watchmen Pension Plan

October 11, 2018

To: ILWU Longshore, Ship Clerk, Walking Boss/Foreman, and Watchmen Locals

From: Mario Perez, Manager, Welfare Plans

Subject: ILWU-PMA Coastwise Indemnity Plan – Annual Other Insurance Coverage

Verification Requirement

The attached letter and form began mailing last week by the Coastwise Claims Office. In order to better receive and track requests for other insurance information, this is an annual mailing each October to collect the information. The mailing will be sent to all members with dependents, unless all covered family members are Retirees with Medicare as their primary carrier. The mailing will not be sent to members whose spouse is also an employee with ILWU-PMA Welfare coverage. Please encourage members to complete the form and return it timely to avoid future claim processing delays. To assist with the tracking, the forms are being returned to the Benefit Plans Office, who will log and then route the form to the CCO. The documents can be mailed or faxed in. Members with Kaiser are required to complete the form as the CCO processes their chiropractic claims.

Attachments

cc: Area Welfare Directors

A copy of this memo can be downloaded at www.benefitplans.org

ILWU-PMA Benefit Plans 1188 Franklin Street, Suite 101 San Francisco, CA 94109 FAX # 415-749-1400

URGENT - RESPONSE REQUIRED BY 11/13/18

Annual Other Insurance Coverage Verification Requirement

Dear ILWU-PMA Coastwise Indemnity Plan Participant:

October 3, 2018

The Plan is requiring completed Other Insurance Coverage Forms on an annual basis for those members that have covered dependents. Each October you will receive notification requesting the completion of the enclosed Other Insurance Coverage (OIC) form. Completing this annual requirement will make it simpler to expedite claim benefit payments for you and your dependents and avoid requests based on individual claim denials for each family member throughout the year.

Even if you have provided this information earlier this year, you will need to submit the completed enclosed form to avoid any delay in your family's claim benefit payments.

Therefore, you must:

Complete, sign and return the Other Insurance Coverage Form enclosed by November 13, 2018.

Fax to: #415-749-1400 OR mail using the enclosed pre-paid addressed envelope.

If you do not return the form:

• Your dependents' benefit claims for dates of service after December 31, 2018 will be denied until the form is received.

Let us know if you have any questions or need help. You can call our Customer Service Office at (800)955-7376.

ILWU-PMA Welfare Plan Other Insurance Verification Form

Return before November 13, 2018 - FAX #415-749-1400

You are required to fill this form out and return even if you have no other insurance

PART A: YOUR IN	FORMATION			The second secon				
LAST NAME	FIRST NAME M.I. Welfare ID			Reg ID	Reg ID BIRTHDATE			
HOME ADDRESS					CITY		STATE	ZIP CODE
TELEPHONE	MARITAL STAT		If no	changes to la	st year's info	rmation select		
	☐ MARRIED ☐	DIVORCED ☐ WIDOW ☐	SINGLE no ch	anges, sign, d	late, and retu	ırn 🗆 NO Changes		
PART B: YOUR DEPENDENT SPOUSE INFORMATION. COMPLETE THIS SECTION FOR YOUR ELIGIBLE SPOUSE								
LAST NAME (PRITY NO.	BIRTHDAT	E SEX (M/F)				
In your anough own	loved? NO	□ VES Plance com	plata Spatian 1 halo					
Is your spouse employed? NO YES – Please complete Section 1 below.								
Is your spouse a retiree? NO YES - If YES, is insurance offered through retirement? NO YES complete Section 2a below.								
Is your spouse covered by Medicare or Medicaid? NO YES-by Medicare Medicaid, complete Section 2a below. Other If YES, complete Section 2a below. Section 1. IF YES, please indicate:								
Section 1. IF YES	, please indicate		de la companya de la La companya de la co					
1. Spouses' Employers Name:								
2. Is your spouse covered by his/her employer's Health Plan? YES - Please complete Section 2a. NO								
		ce information:			ere registroppe e Sag			
2a. If YES, please	indicate:	, , , , , , , , , , , , , , , , , , , ,				G		
Other Insurance Company's Name:						Comments:		
Other Insurance Co	mpany's Name: _							
Address:								
Phone No:								
			m.	D .				
Policy Number:		Effective Date:	I erm	Date:				
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insurance type.	mny Coverage Typ							
			(Check all that ap	,				
		LDREN INFORMATIO Student, Accident, o				INSURED UNDER ANY (THER GROUP	MEDICAL OR
Dependent (·	erage offered b			Po	licy Number and
(for more children t		Dependent SSN	(Name of Non-IL)			Insurance Name		Effective Date
		L	CONSE	NT INFORM	IATION			
By my signature b	elow, I acknowle	edge that the ILWU-Pl	MA Plan and its at	thorized agents	may use and d	isclose health information	on for purpose	s related to evaluating,
processing, and reviewing my claims or my dependent's claims, and I consent to the disclosure of information requested by the ILWU-PMA Welfare Plan by any								
medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policy holder, employer or benefit plan administrator.								
I hereby certify that	all information n	rovided on this form is	accurate and comple	ete to the hest of	my knowledge			
I hereby certify that	иногинаноп р	.oaca on this form is	accurate and compr	olo to the best of	y kilowicuge.			
ILWU-PMA Plan Covered Employee Signature Date								