ILWU-PMA BENEFIT PLANS /
International Longshore & Warehouse Union —
Pacific Maritime Association www.benefitplans.org
1188 FRANKLIN STREET • SUITE 101 • SAN FRANCISCO, CALIFORNIA 94109
PHONE (415) 673-8500
FAX (415) 749-1321

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

Date October 17, 2025

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

From: Mario Perez, Welfare Plan Director

Subject: ILWU-PMA Welfare Plan - Coastwise Claims Office
Annual Other Insurance Coverage Verification Requirement

The attached letter and form began mailing this week by the Coastwise Claims Office(CCO). To better receive and track requests for other insurance information, this is an annual mailing each year to collect the information. The mailing will be sent to all members. Members can fax, mail, or log in to a secure website to complete and submit the information. Please encourage members to complete the process timely to avoid future claims processing delays. Members with Kaiser are also required to complete the process 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 Coastwise Claims Office
PO Box 429101
San Francisco, CA 94142
FAX # 415-646-4414

October 13, 2025

****** REVISED CONTENT PLEASE READ CAREFULLY ******

Please complete this form online using the link below

https://edge.zenith-american.com/

or if you prefer, you may return by fax or by mail in the enclosed envelope. If you do not return the enclosed form by December 31, 2025, claims for your dependents will be denied until this form is received.

Dear ILWU-PMA Welfare Plan Participant:

The Plan requires ALL members with covered dependents to complete an Other Insurance Coverage Form on an annual basis. Even if you have submitted this information earlier this year, enrolled in Medicare, or dual cover under the ILWU-PMA Welfare Plan, you are still required to complete the enclosed form to avoid delays in processing your family's medical claims.

In addition to members with dependents, the following individuals are also required to provide information about other insurance coverage: **Surviving Spouses, Surviving Children, and Non-Medicare Retirees**.

Individuals in these groups may have other insurance that could be considered primary to the ILWU-PMA Welfare Plan coverage. To properly coordinate benefits, the Coastwise Claims Office must have up-to-date details about any OTHER insurance coverage **that you, your spouse, or dependents may have in addition to ILWU-PMA coverage.**

To provide updated information for the Plan please follow the instructions below:

Fastest and Easiest Option: Submit Online

The most efficient way to complete your form is online at the secure Participant Edge portal, provided by Zenith American Solutions: https://edge.zenith-american.com/ Visit the site and click LOGIN on the home page. Select "Participant Edge." Register as a first-time user or log in if you already have an account. On the left side, click on "Other Insurance." On the right side, click the blue box labeled "Start Update." Follow the prompts to enter the required information. You must complete an update for each person covered under your plan. Finally, confirm your electronic signature and keep the reference number for your records.

For additional questions or concerns, click "Contact Us" located just below the "Other Insurance" box.

- **CIP members in WA/OR: Enter the number from your insurance card under Participant ID in the Alternate ID field**
- **CIP members in CA: Enter the number from your card under Participant ID, (omit the "WUE"), in the Alternate ID field**
- **Kaiser members: Enter the number from your Chiro card under Member ID into the Alternate ID field**
- **If you DO Not have an ID card yet:**
    - **You may call us to obtain your ID number,**
    - **Or simply return the enclosed form by mail or fax. Be sure to enter your longshore registration number in the "Welfare ID" box.**

You may complete the enclosed paper form and submit it by:

Fax to (415) 646-4414 OR mail using the enclosed pre-paid addressed envelope

If you have any questions or need assistance with this process, please contact the Coastwise Claims Customer Service Office at (800) 955-7376.

ILWU-PMA WELFARE PLAN – OTHER INSURANCE VERIFICATION FORM
Complete, Sign and Return Before December 31, 2025

YOU ARE REQUIRED TO FILL OUT THIS FORM AND RETURN IT. IF YOU DO NOT RETURN THIS FORM COMPLETED BY THE DATE INDICATED ABOVE, YOUR SPOUSE'S AND/OR DEPENDENTS' CLAIMS WILL BE DENIED UNTIL THE FORM IS RETURNED.

Part A: Your Information

(Reminder: Certain surviving spouses who remarry may no longer be eligible for coverage and are required to notify the Plan within 30 days of the event. Reminder: This form is not for adding or deleting dependents. Please contact the ILWU-PMA Benefit Plans at (888) 372-4598 for additions or deletions.)

Legal Last Name:	Legal First Name:	Middle Initial:	Welfare ID/Registration #:	Date of Birth:	
Home Address:		City:		State:	Zip Code:
Telephone:	Marital Status: ☐ Married ☐ Separated ☐ Widow ☐ Remarried ☐ Divorce (date _____) ☐Never Married				

Part B: Do you have any insurance other than ILWU-PMA Medical Insurance? (Medicaid, Medicare, retiree, student, private, etc.) If **YES, complete the table:**

Insurance Name:	Insurance Number:
Insurance Policy Number:	Effective Date:

Part C: Do you have any additional (tertiary) insurance coverage beyond your primary and secondary plans?

Insurance Name:	Insurance Number:
Insurance Policy Number:	Effective Date:

Part D: Spouse and/or Dependent Children, Surviving Spouses, Surviving Children, and Non-Medicare Retirees Information. Are your dependents covered by any other medical insurance?
(Student, Medicaid, Medicare, Retiree, Private, ILWU-PMA, etc.) If **YES, complete the table:**

Dependent Name (for more children use back of form)	**Date of Birth**	**Insurance Name and Number**	**Policy/ID Number**	**Effective Date**	**Dependent Type:**
					☐ Spouse ☐ Child ☐ Other
					☐ Child ☐ Other
					☐ Child ☐ Other
					☐ Child ☐ Other
					☐ Child ☐ Other
					☐ Child ☐ Other
					☐ Child ☐ Other
					☐ Child ☐ Other
					☐ Child ☐ Other

By my signature below, I acknowledge that the ILWU-PMA Coastwise Claims Office and its authorized agents may use and disclose health information for purposes 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 Coastwise Claims Office, 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. This consent will be valid for the entire period of my eligibility and my dependent's eligibility under the Plan. I hereby certify that all information provided on this form is accurate and complete to the best of my knowledge.

_____ _____

Signature of member or insured Date

COMPLETE, SIGN AND RETURN FORM TO: ILWU-PMA Coastwise Claims Office PO Box 429101, San Francisco, CA 94142

FAX: (415) 646-4414

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