

# Alaska United Food and Commercial Workers Trust Funds

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Administered by  
Welfare & Pension Administration Service, Inc.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
----- Member Name: \_\_\_\_\_  
----- WPAS ID Number: \_\_\_\_\_

**Please note that this is the only request for information that you will receive. Failure to respond within 45 days may result in denial of this claim.**

Before we can process claims for this dependent child, we must ask you to answer the following questions:

1. What is our member's relationship to the above child? (Check one)  
 Natural Mother  Step-Mother  
 Natural Father  Step-Father  
 Other, please explain: \_\_\_\_\_

Name of child's natural parents \_\_\_\_\_

Natural parent's divorce date if applicable \_\_\_\_\_

If natural parents have remarried, please indicate name of new spouse and date of marriage.

Mother \_\_\_\_\_

Father \_\_\_\_\_

2. With whom does the child reside? Name \_\_\_\_\_  
Address \_\_\_\_\_  
Relationship to child \_\_\_\_\_

3. Does the divorce decree state who is financially responsible for the child's health care expenses?  
 Yes  No (If yes, please indicate the name of person financially responsible):  
\_\_\_\_\_

4. Natural Mom date of birth: \_\_\_\_\_ Natural Dad date of birth \_\_\_\_\_  
**Please send copy of divorce decree and parenting plan or other court documents assigning financial responsibility.**

Does this child have other insurance coverage?  Yes  No

If child is covered by more than one plan please indicate name and address of other insurance carrier. Include that member's name, policy and group no.

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\_\_\_\_\_  
Member's Signature

\_\_\_\_\_  
Date

**The handling period for this claim is 30 days. Due to this request for information, which is necessary to decide the claim, the handling period on this claim is extended by 15 days.**

WPAS Employee Benefit Department

Email [claimstatus@wpas-inc.com](mailto:claimstatus@wpas-inc.com)