Alaska United Food and Commercial Workers Trust Funds

P.O. Box 34945 ● Seattle, Washington 98124
Phone (206) 441-7574 ● Toll-Free (800) 478-8329 ● Fax (206) 441-9110 ● Email www.akufcwtrust.com

Administered by
Welfare & Pension Administration Service, Inc.

Date:

Patient Name:
Address:

Member:
WPAS ID Number:

Because your medical coverage has a provision, which requires that we consider other medical coverage that might be available; you must complete this form and return to us at the above address. **This reply must be in writing, we cannot take this information over the phone.**

Is _____ spouse employed? ☐ Yes ☐ No
Does your spouse's employer provide access to health insurance? ☐ Yes ☐ No
Was that coverage declined? ☐ Yes ☐ No
If declined, **what date would the coverage have become effective**? **_____**

Aside from this coverage with Alaska United Food & Commercial Workers Trust Fund, do you, your spouse or children have any other group insurance, health plan, Medicare or Medicaid?
☐ Yes ☐ No If yes, please give the name and the address of other insurance company:
_____

Telephone number: _____ Name of insured: _____

Insured's birth date: _____ Policy #:_____ Insured's SSN: _____

Effective date of coverage: _____ Is this active, cobra or retiree coverage? _____

Check what the coverage includes: ☐ Medical ☐ Dental ☐ Vision /
☐ Member ☐ Spouse ☐ Dependents

Name of group or employer this coverage is through: _____

If the coverage has since terminated, please indicate the date coverage ended: _____

If you or your dependents are covered by more than one plan please indicate the name and address of other insurance carrier. Include that member's name, policy and group number. Use the reverse side of this form if needed.

_____ _____
Signature of Member Date

If you have any questions, please contact our office.
WPAS Employee Benefit Department **claimstatus@wpas-inc.com**