Trust Fund Office
LABORERS HEALTH & WELFARE TRUST FOR SOUTHERN CALIFORNIA
1123 Park View Drive, Suite 200 • Covina, CA 91724
PO Box 3389 • Covina, CA 91722
Tel 626-279-3000 • 1-800-887-5679 • Fax 626-279-3094

Date: _______________

Participant's Name: ____________________________

Re: Other Insurance Information
xxx-xx-___________

Dear Participant:

Under the terms of the Plan, you are not entitled to be paid more than 100% of your covered expenses from this Plan and any other plan that may provide coverage for medical, dental or vision benefits to you, your spouse or your eligible dependent children.

1. Are you covered under any other group health Plan?	Yes	No
2. Is your spouse (husband/wife) covered under any other group health Plan?	Yes	No
3. Is any eligible dependent child covered under any other group health Plan?	Yes	No

Please circle Yes or No. If you circled No to all three questions, please sign below and return this letter in the envelope provided. If you circled Yes, please complete the information requested for each individual who has other insurance:

Insured Name: ________________________________ Relationship___________________

Date of birth: ______/______/_______

Other Plan Name ____

Address____

Group or Policy #: ____________ Medical_______ Dental________ Effective date: ____/____/____

Is this **Family** or **Individual** Coverage? (Please circle one and submit a ***copy*** of the other Insurance Card(s))

Insured Name: ________________________________ Relationship___________________

Date of birth: ______/______/_______

Other Plan Name ____

Address____

Group or Policy #: ____________ Effective date: ____/____/____

Is this **Family** or **Individual** Coverage? (Please circle one and submit a ***copy*** of the other Insurance Card(s))

I hereby certify that the foregoing statements are to the best of my knowledge and belief true, correct and complete. If this statement changes in any way, I agree to contact The Trust Fund office immediately.

____ ______________________

Participant's Signature (Plan Member) **Month Day Year**

Any person making a willful misrepresentation in completing this form shall be liable to the Plan for any loss to the Plan resulting from such misrepresentation. Refer to the Summary Plan Description Section, "Coordination of Benefits with Other Plans" for the specific Plan provision.