



# Writers' Guild-Industry Health Fund

Terence L. Young, Chief Executive Officer

Dear Participant:

Your Writers' Guild-Industry Health Fund (FUND) Plan contains a Coordination of Benefits provision. Please respond to this questionnaire and return to the FUND at the address listed below so we may update your records.

## SECTION A

Participant's Name: \_\_\_\_\_ ID# \_\_\_\_\_

- I and/or my dependents DO NOT have other group health insurance coverage. (Complete Section C)
- I and/or my dependents have other group health coverage (you must complete Section B and C indicating the other coverage). YOU MUST COMPLETE A SEPARATE FORM FOR EACH INSURANCE COMPANY.

## SECTION B

Insurance Company Name/Health Fund \_\_\_\_\_

Address: \_\_\_\_\_ Phone#: \_\_\_\_\_

Policyholder/Participant's Name: \_\_\_\_\_

Identification Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Effective Date: \_\_\_\_\_ Policy Type:  Medical  Dental

Active Coverage  Retired Coverage  COBRA Coverage  Self Pay

Covered Persons

Relationship:

|       |       |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## SECTION C

It is my responsibility to ensure that accurate information is maintained and kept updated regarding my other health/dental insurance. If other coverage is added or terminated for any individuals covered under my Writers' Guild-Industry Health Fund Plan, I must notify the Fund immediately.

I certify the above information is accurate.

Participant's Signature \_\_\_\_\_ Date: \_\_\_\_\_

**THIS FORM MUST BE RETURNED TO THE FUND OFFICE TO EXPEDITE CLAIM PROCESSING.**