PWGA
Pension & Health Plans
YOUR TRUSTED GUIDE

Writers' Guild Industry-Health Fund
Coordination of Benefits Form

Please submit this form with all supporting documentation to The Fund

Mailing Address: 2900 West Alameda Ave., Suite 1100, Burbank, CA 91505 or access this form on our website at: www.wgaplans.org

SUBSCRIBER INFORMATION (Please Print Clearly or Type)

Participant's Name: _____ Participant ID # **WRXA** _____

Spouse's Name: _____ Spouse's Date of Birth: _____

Spouse's Employer Address/Phone Number _____

_____

COVERAGE INFORMATION

Please note: If you, your spouse or dependent(s) have: (check applicable box)

- ☐ No other group health insurance coverage, then sign and date the form in Part D
- ☐ Other coverage, please complete Part A1, then sign and date the form in Part D
- ☐ Been Divorced/legally separated, please complete Part A and Part B, then sign and date the form in Part D
- ☐ Medicare coverage, please complete Part C, then sign and date the form in Part D

Part A

If you, your spouse or dependent(s) have other coverage, list each separately

Carrier Name: _____

Carrier Address: _____ Telephone #: _____

Subscriber's Name: _____ Policy/Group #: _____ Subscriber's ID #: _____

Policy Effective Dates: Start: _____ End: _____ Covered Dependents _____

_____

_____

Coverage Type:
(Check applicable) ☐ Medical ☐ Mental Health ☐ Prescription ☐ Dental

Type of Plan:
☐ Retiree ☐ COBRA ☐ Individual ☐ Self Pay ☐ Active

Carrier Name: _____

Carrier Address: _____ Telephone #: _____

Subscriber's Name: _____ Policy/Group #: _____ Subscriber's ID #: _____

Policy Effective Dates: Start: _____ End: _____ Covered Dependents _____

_____

_____

Coverage Type:
(Check applicable) ☐ Medical ☐ Mental Health ☐ Prescription ☐ Dental

Type of Plan:
☐ Retiree ☐ COBRA ☐ Individual ☐ Self Pay ☐ Active

If previous coverage terminated within the last two years, you must enclose documentation from the former carrier indicating the date the policy was terminated.

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COVERAGE INFORMATION (Continued)

Part B

Please complete this section if you are divorced or legally separated, and you have dependent children covered under this plan.

1. Does the other custodial parent of your dependent children provide health benefits? ☐ Yes ☐ No

Name of other custodial parent:_____ Birth date:_____

If yes, please provide the following information:

Name of other health plan: _____

Policy/Group #:_____

Subscriber ID #:_____

Which children are covered?_____

2. If divorced, check one of the following: Date of divorce/separation:_____

☐ Divorce decree stipulates other parent must provide health benefits

☐ Divorce decree stipulates joint custody

☐ Divorce decree does not stipulate any special provisions

☐ Other, please explain:_____

_____

** A copy of the section of the court decree pertaining to health coverage or other documents must be provided to support your response.*

*** IMPORTANT NOTE: If you are over age 65, you must enroll in Medicare part A & B ***

Part C

You should complete this section if you, your spouse, and/or your dependents are eligible for Medicare. Please enclose a copy of the Medicare ID card for each eligible member of your family.

Name of **Participant** eligible for Medicare:

_____

Effective Dates of Medicare:

Part A:_____ Part B:_____

Name of **Dependent** eligible for Medicare:

_____

Effective Dates of Medicare:

Part A:_____ Part B:_____

If you are under age 65 are you enrolled in Medicare due to a disability? ☐ Yes ☐ No

Part D

PARTICIPANT SIGNATURE

Signature and date is required

I certify that the above information is correct and understand that I am obligated to provide this information to the Writers' Guild Health Fund with the Certificate of Coverage. 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. Failure to provide complete and accurate information may result in a delay in the payment of benefits and/or can result in the incorrect handling of your claim.

Print Your Name: _____

Signature: _____ Date:_____

Participant ID Number: **WRXA**

WRITERS' GUILD-INDUSTRY HEALTH FUND
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Suite 1100
BURBANK, CA 91505
ATTN: CLAIMS DEPARTMENT
Phone Number: (818) 846-1015 or (800) 227-7863