MO-KAN TEAMSTERS
HEALTH AND WELFARE FUND

PO Box 909500
Kansas City, MO 64190-9500

INFORMATION VERIFICATION FORM

Please complete the front and back of this form, sign at the bottom of the last page and return. This form can be emailed or faxed to the contact information listed above.

Participant Information

Check One: ❑ Male ❑ Female

Last Name _____ First Name _____ Middle Initial _____

Social Security Number _____ Birth Date (MM/DD/YYYY) _____ (_____) _____
Area Code Phone Number

Home Address _____ Apartment Number _____

City _____ County _____ State _____ Zip Code _____ Email Address _____

Check One: ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced: _____
Date of Divorce (MM/DD/YYYY)

Check the following languages in which you are literate: ❑ English ❑ Spanish ❑ Other

Are you a policyholder of any other group medical, vision or dental plan other than Medicare? ❑ Yes ❑ No

Are you entitled to Medicare Part A or B? ❑ Yes ❑ No *If yes, submit a copy of your Medicare Card if it has not been previously submitted.*

Is your spouse offered group health coverage through his/her employer (whether they have accepted the other coverage or not)? ❑ Yes ❑ No

Dependent Information

List all eligible dependents to be covered.

If you are adding a spouse, please include a copy of your marriage certificate. County filed copies only. Souvenir copies are not accepted.
If you are adding a child, please include a copy of their birth certificate. State issued copy only. Souvenir copies are not accepted.
If either you or your spouse are divorced and you are adding a child or stepchild, submit a copy of the divorce decree and any settlement agreement made part of the decree stating custody and medical responsibility for the children. The decree must be signed and dated by the judge.

Relationship (Spouse, Son, Stepdaughter)	Social Security Number	Last Name	First Name and Middle Initial	Date of Birth (MM/DD/YYYY)	Does this person have other group medical, vision, prescription, or dental coverage? (Including Medicare)
Spouse: ☐ M ☐ F					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No
					❑ Yes ❑ No

Note: This form MUST be signed and dated on page 2 to be valid

If a dependent child or stepchild is listed and the child's parents are divorced, submit a copy of the divorce decree and complete the following for each affected child:

Last Name	**First Name and Middle Initial**	**Who has custody?**	**Who has Medical Responsibility as stated in the Divorce Decree?**	**Does the child live in your home?** *If no, please provide child's home address.*
				❑ **Yes** ❑ **No**
				❑ **Yes** ❑ **No**
				❑ **Yes** ❑ **No**

Declaration of Other Coverage

Please complete for the Participant and each dependent that has any other group medical, vision, prescription, or dental coverage (including Medicare). Attach a separate sheet if necessary. Submit a copy of card(s) for each carrier.

Other Policy #1

Policy Holder:_____ Policy or Group Number: _____

Policy Holder's Social Security Number:_____ Does the plan cover dependents? ❑ Yes ❑ No

Plan Name:_____ Employer's Name: _____

Plan Address:_____ Plan Phone Number: _____

Status for Plan Coverage: ❑ Active ❑ Retired Follows Birthday Rule*: ❑ Yes ❑ No

Effective Date of Coverage:_____ Termination Date: _____

Benefits Provided:

Medical: ❑ Yes ❑ No Dental: ❑ Yes ❑ No Vision: ❑ Yes ❑ No Mental Health/Substance Abuse: ❑ Yes ❑ No Prescription: ❑ Yes ❑ No

Other Policy #2

Policy Holder:_____ Policy or Group Number: _____

Policy Holder's Social Security Number:_____ Does the plan cover dependents? ❑ Yes ❑ No

Plan Name:_____ Employer's Name: _____

Plan Address:_____ Plan Phone Number: _____

Status for Plan Coverage: ❑ Active ❑ Retired Follows Birthday Rule*: ❑ Yes ❑ No

Effective Date of Coverage:_____ Termination Date: _____

Benefits Provided:

Medical: ❑ Yes ❑ No Dental: ❑ Yes ❑ No Vision: ❑ Yes ❑ No Mental Health/Substance Abuse: ❑ Yes ❑ No Prescription: ❑ Yes ❑ No

* The birthday rule is a coordination of benefits rule that some plans use to determine which coverage is primary.

Acknowledgement

If married, both the Participant and Spouse must sign below.

I understand that if I or my dependents provide false information to the Mo-Kan Teamsters Health and Welfare Fund or conceal information, we could be subject to severe penalties under state and federal law and the Fund may seek to recover benefits wrongfully paid or pursue legal remedies against us. I declare under penalty of perjury that the foregoing is true and correct.

AUTHORIZATION

I agree, for myself and my dependents, that in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act of omission of another person to fully inform Mo-Kan Teamsters Health and Welfare Fund and that I will execute such assignments, liens or other documents which maybe necessary to enable Mo-Kan Teamsters Health and Welfare Fund to recover the value of benefits provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided, I will immediately reimburse Mo-Kan Teamsters Health and Welfare Fund to the extent of services provided and to the extent as specified by the plan. **FRAUD WARNING** Any person who, knowingly and with intent to defraud the Fund or other person: (1) files an application for benefits or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits, a fraudulent act and may be subject legal action

_____ _____

Participant's Signature Date

_____ _____

Spouse's Signature Date

FOR INTERNAL USE ONLY

MC REC:_____ BC REC:_____ DD REC:_____ REQ ON:_____ BY: _____