

ARIZONA SHEET METAL TRUST FUNDS

HEALTH AND WELFARE

ADMINISTRATIVE OFFICE

PENSION

2400 W. Dunlap Ave., Suite 250
Phoenix, AZ 85021
(602) 249-3582

OTHER INSURANCE INFORMATION

PARTICIPANT: _____ SS#: _____

NAME OF INSURED: _____ SS#: _____

EMPLOYER NAME: _____ PHONE #: _____

Please have the insured's employer fill out the information listed below. This information is needed before we can process claims on your spouse and dependent(s).

MEDICAL INFORMATION

1. IS EMPLOYEE COVERED BY GROUP INSURANCE:

NO YES EFFECTIVE DATE: _____

IF NO, WHY?

1. NOT YET ELIGIBLE WHAT WILL BE THEIR EFFECTIVE DATE? _____

2. ELECTED NOT TO TAKE COVERAGE

3. COVERAGE NOT OFFERED

4. IF COVERAGE TERMED, TERM DATE _____

2. DOES INSURANCE INCLUDE DEPENDENTS? YES NO

3. NAME, ADDRESS AND PHONE NO. OF CARRIER: _____

PHONE NO. _____

DENTAL INFORMATION

4. DOES PLAN INCLUDE DENTAL COVERAGE? YES NO

IF YES: FOR SELF ONLY FOR SELF AND DEPENDENTS

EFFECTIVE DATE: _____ TERMINATION DATE OF COVERAGE: _____

5. NAME, ADDRESS AND PHONE NO. OF CARRIER: (if different from above)

PHONE NO. _____

6. NAME AND TITLE OF PERSON WHO PROVIDED INFORMATION:

7. SIGNATURE: _____ DATE: _____

THANK YOU
SOUTHWEST SERVICE ADMINISTRATORS, INC.