Laborers and Operating Engineers Utility Agreement Trust Funds for Arizona

HEALTH AND WELFARE | ADMINISTRATIVE OFFICE | VACATION

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.