

# PHOENIX PAINTING INDUSTRY TRUST FUND

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.