UNITED FOOD AND COMMERCIAL WORKERS & EMPLOYERS
Arizona Health & Welfare Trust

ADMINISTRATOR: Southwest Service Administrators, Inc.
2400 W. Dunlap Ave., Suite 250 • Phoenix, AZ 85021 • Phone 602-249-3582 • Toll Free 1-800-474-3485 • Fax 602-249-3795

How to fill out the Other Insurance Information Letter

****ONLY have this form filled out if there is or will be other insurance****

The purpose of this form is to prevent any delays in the processing of the claims on your spouse and or dependents.

- **UFCW Participant:** The name and social security number of the UFCW enrollee.
- **Name of Insured:** The name and social security number of the person who has other insurance.
- **Employer Name:** The name of the employer and phone number of the insured.

*****Take this form to the Insured persons Human Resource Department through their employer and have them complete the rest of this form. DO NOT LEAVE BLANK SPACES.*****

*****If you have NO OTHER INSURANCE fill out a claim form and disregard this form.*****

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Como llenar la carta de otra aseguranza

SOLAMENTE llene esta forma cuando tenga otra aseguranza

El objeto de esta forma es para impedir demorar el proceso de reclamos de su cónyuge y sus dependientes.

- **UFCW Participante:** El nombre y el número de seguro social del miembro de UFCW.
- **Nombre De Asegurado:** El nombre y el número de seguro social de la persona que tenga otra aseguranza.
- **Nombre De Empleado:** El nombre y número de teléfono del asegurado.

*****Es necesario que el asegurado lleve esta forma al empleador y que el empleador la llene con la información necesitadad. NO DEJEN PREGUNTAS EN BLANCO.*****

*****Si no tiene OTRA ASEGURANZA solamente llene una forma de beneficios.*****

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OTHER INSURANCE INFORMATION

UFCW PARTICIPANT: ______________________ **SS #:** ______________________

NAME OF INSURED: ______________________ **SS #:** ______________________

EMPLOYER NAME: ______________________ **PHONE #:** ______________________

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

MEDICAL INFORMATION

1. **DATE OF HIRE:** ______________________

2. **IS EMPLOYEE COVERED BY GROUP INSURANCE:**

   ☐ No ☐ Yes EFFECTIVE DATE: ___________

   IF NO, WHY?

   A. ☐ NOT YET ELIGIBLE — WHAT WILL BE THEIR EFFECTIVE DATE? ___________

   B. ☐ ELECTED NOT TO TAKE COVERAGE — IF NOT - WHY? ______________________

   C. ☐ COVERAGE NOT OFFERED — OPEN ENROLLMENT DATE: ______________

   D. IF COVERAGE TERMED, TERM DATE: ______________________

3. **DOES INSURANCE INCLUDE DEPENDENTS?** ☐ Yes ☐ No

4. **NAME, ADDRESS AND PHONE # OF CARRIER:** ______________________

   ____

   ______________________ PHONE #: ___________

DENTAL INFORMATION

5. **DOES PLAN INCLUDE DENTAL COVERAGE?** ☐ Yes ☐ No

   IF YES: ☐ FOR SELF ONLY ☐ FOR SELF AND DEPENDENTS

   EFFECTIVE DATE: ______________ TERMINATION DATE OF COVERAGE: ___________

6. **NAME, ADDRESS AND PHONE # OF CARRIER:** (if different from above)

   ____

   ____

   ______________________ PHONE #: ___________

7. **NAME AND TITLE OF PERSON WHO PROVIDED INFORMATION:**

   ______________________ ______________________

8. **SIGNATURE:** ______________________ **DATE:** ______________________

THANK YOU

SOUTHWEST SERVICE ADMINISTRATORS, INC.