BAY AREA DELIVERY DRIVERS SECURITY FUND

4160 DUBLIN BLVD., SUITE. 400 • DUBLIN, CA 94568-7756
TEL. (925) 833-7303 • TOLL FREE (800) 654-1824 • FAX (925) 833-7301

DUAL COVERAGE QUESTIONNAIRE

Dear Participant:

Information has been received indicating that you and/or your dependent(s) may be eligible under another Group Insurance Plan. In order to determine the primary carrier for your benefits please answer the questions below. All claims will be pending your reply to this questionnaire.

PLEASE COMPLETE ALL QUESTIONS

Employee Name: ____ BADD ID#: ________________________

1. Do you and/or your eligible dependent(s) have any other group Medical or Dental benefits? YES ____ NO ____

   If "yes" please give names of all family members covered by another group plan: ________________________

   ____

2. Provide birthdate of both parents: Mother: ___ /___ /___ Father: ___ /___ / ___

3. Does child/children live with both natural parents? YES _____ NO _____

4. If parents are divorced or separated, which parent has custody? Mother _____ Father_____

5. If divorced, is it specifically written in your divorce decree which parent is responsible for all health expenses for this child? YES _____ NO_____

   If yes, please attach a copy of the portion of your divorce decree that explains the responsibility:

6. Please provide the following information regarding insurance coverage for you and your dependents.
   - Name of other insured person: ____
   - Is insured actively working or retired? ______________ If retired, date of retirement? ____________
   - Relationship to dependent(s) (mother, father, stepparent): ___________________________________
   - Name and address of other insured's employer: ____

     ____
   - Other insured's I.D. or Social Security No.: ____
   - Name, address and phone number of other group carrier for **Medical** care: ______________________

     ____
   - Policy No.: ___________________________________ Effective date of coverage: _____________
   - If terminated, date of termination: ______________
   - **IS THIS AN HMO PLAN?** YES _____ NO_____
   - Name, address and phone number of other group carrier for **Dental** care: _______________________

     ____
   - Policy No.: ___________________________________ Effective date of coverage: _____________
   - If terminated, date of termination: ______________
   - **IS THIS AN HMO PLAN?** YES _____ NO_____

7. Submit a copy of your other coverage's Identification Card (ID card) with this completed form.

PLEASE SIGN ON BACK OF THIS FORM

Revised 09.17.2019

I understand that it is illegal, and a felony in some states, for any person to knowingly and with intent to injure, defraud, or deceive any insurer, file a statement of claim or an enrollment request containing any false, incomplete, or misleading information. In some states, anyone found guilty of insurance fraud is subject to fines, confinement in prison, and/or denial of insurance benefits.

Member's Signature ___________________________________ Date Signed: ________________________

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE TO:

Bay Area Delivery Drivers Security Fund
4160 Dublin Blvd., Suite 400
Dublin, CA 94568-7756

OR FAX TO: 925-833-7301

ALL CLAIMS SUBMITTED WILL BE HELD PENDING YOUR REPLY

USE THE SPACE BELOW FOR ANY ADDITIONAL INFORMATION