

BAY AREA DELIVERY DRIVERS SECURITY FUND



4160 DUBLIN BLVD., SUITE. 100 • 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
Em	ployee 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 <u>specifically written</u> 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.

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 fines, confinement in prison, and/or denial of insurance benefits	found guilty of insurance fraud is subject to		
Member's Signature	Date Signed:		

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE TO:

Bay Area Delivery Drivers Security Fund 4160 Dublin Blvd., Suite 100 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