

Writers' Guild-Industry Health Fund



Dear Participant:

Your Writers' Guild-Industry Health Fund (FUND) Plan contains a Coordination of Benefits provision. Please respond to this questionnaire and return it to the FUND at the address listed below so we may update your records. Please be sure to sign and date this form on the reverse side.

SECTION A

Participant's Name: _____ ID# _____

Spouse' Name: _____ Employed? Yes No

If employed: Employer: _____

Phone #: _____

- I and/or my dependents do NOT have other group health insurance coverage. (**Complete Section C**)
- I and/or my dependents DO have other group health coverage (you **must complete Section B and C indicating the other coverage**).

SECTION B

Insurance Company Name/Health Fund _____

Phone#: _____ Policyholder/Participant's Name: _____

Identification Number: _____ Group Number: _____

Effective Date: _____ Policy Type: Medical Dental Rx

Active Coverage Retiree Coverage COBRA Coverage Individual Self-Pay

Covered Persons

Relationship

_____	_____
_____	_____
_____	_____
_____	_____

Please see reverse side

SECTION B (Continue)

Insurance Company Name/Health Fund _____

Phone#: _____ Policyholder/Participant's Name: _____

Identification Number: _____ Group Number: _____

Effective Date: _____ Policy Type: Medical Dental Rx

Active Coverage Retiree Coverage COBRA Coverage Individual Self-Pay

Covered Persons

Relationship

_____	_____
_____	_____
_____	_____
_____	_____

If you previously had coverage with another plan and it has terminated, please include a copy of the termination letter with this form.

SECTION C - A signature and date is required.

It is my responsibility to ensure that accurate information is maintained and kept updated regarding my other health/dental/Rx insurance. If other coverage is added or terminated for any individuals covered under my Writers' Guild-Industry Health Fund Plan, I must notify the Fund immediately.

I certify the above information is accurate.

Participant's Signature _____ Date: _____

THIS FORM MUST BE RETURNED TO THE FUND OFFICE AT THE ADDRESS BELOW TO EXPEDITE CLAIM PROCESSING.

WRITERS' GUILD-INDUSTRY HEALTH FUND
1015 N. HOLLYWOOD WAY
BURBANK, CA 91505
ATTN: CLAIMS DEPARTMENT

Phone Number: (818) 846-1015 or (800) 227-7863
Fax Number: (818) 566-8445 or 566-4416