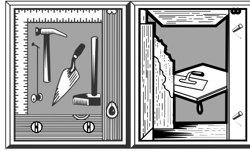
**Information Verification Form**



# BAC Local Union 15 Welfare Fund

PO Box 909500 • Kansas City, MO 64190-9500
Phone (816) 777-2668 • Toll Free (833) 479-9428 • Fax (816) 756-3659
BAC-Eligibility@wilson-mcshane.com

*Please complete the front and back of this form, sign at the bottom of the last page and return. This form can be emailed or faxed to the contact information listed above.*

**Participant Information**

Check One: ☐ Male ☐ Female

Last Name ______ First Name ______ Middle Initial ______

Social Security Number ______ Birth Date (MM/DD/YYYY) ______ ( ) ______ Cell Phone Number

Home Address ______ Apartment Number ______ ( ) ______ Home Phone Number

City ______ County ______ State ______ Zip Code ______ Email Address ______

Check One: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced: ______ Date of Divorce (MM/DD/YYYY)

Check the following languages in which you are literate: ☐ English ☐ Spanish ☐ Other ______

Are you a policyholder of any other group medical, vision or dental plan other than Medicare? ☐ Yes ☐ No

Are you entitled to Medicare Part A or B? ☐ Yes ☐ No *If yes, submit a copy of your Medicare Card if it has not been previously submitted.*

## Dependent Information

*List all eligible dependents to be covered.*

*If you are adding a spouse, please include a copy of your marriage certificate. County filed copies only. Souvenir copies are not accepted. If you are adding a child, please include a copy of their birth certificate. State issued copy only. Souvenir copies are not accepted.*
*If either you or your spouse are divorced and you are adding a child or stepchild, submit a copy of the divorce decree and any settlement agreement made part of the decree stating custody and medical responsibility for the children. The decree must be signed and dated by the judge.*

| Relationship (Spouse, Son, Stepdaughter) | Social Security Number | Last Name | First Name and Middle Initial | Date of Birth (MM/DD/YYYY) | Does this person have other group medical, vision, prescription or dental coverage? (Including Medicare) |
|---|---|---|---|---|---|
| Spouse: ☐ M ☐ F | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |
| | | | | | ☐ Yes ☐ No |

Note: This form MUST be signed and dated on page 2 to be valid

*If a dependent child or stepchild is listed and the child's parents are divorced or have legal documents regarding medical responsibility and/or custody, submit a copy of the legal document. The document must show where it was filed with the court. Complete the following for each affected child:*

| Last Name | First Name and Middle Initial | Who has custody? | Who has Medical Responsibility as stated in the legal documents? | Does the child live in your home? *If no, please provide the child's home address.* |
|---|---|---|---|---|
| | | | | ☐ Yes<br>☐ No |
| | | | | ☐ Yes<br>☐ No |
| | | | | ☐ Yes<br>☐ No |

### Declaration of Other Coverage

*Please complete for the Participant and each dependent that has any other group medical, vision, prescription or dental coverage (including Medicare.) Attach a separate sheet if necessary. Submit a copy of card(s) for each carrier.*

**Other Policy #1**

Policy Holder: ____________________ Policy or Group Number: ____________________

Policy Holder Social Security Number: ____________________

Does this plan cover dependents? Yes No If yes, who does it cover? List all: ____________________

Plan Name: ____________________ Employer's Name: ____________________

Plan Address: ____________________ Plan Phone Number: ____________________

Status of Plan Coverage: Active Retired Follows Birthday Rule*: Yes No

Effective Date of Coverage: ____________________ Termination Date: ____________________

Benefits Provided: Medical: Yes No Prescription: Yes No Dental: Yes No Vision: Yes No

**Other Policy #2**

Policy Holder: ____________________ Policy or Group Number: ____________________

Policy Holder Social Security Number: ____________________

Does this plan cover dependents? Yes No If yes, who does it cover? List all: ____________________

Plan Name: ____________________ Employer's Name: ____________________

Plan Address: ____________________ Plan Phone Number: ____________________

Status of Plan Coverage: Active Retired Follows Birthday Rule*: Yes No

Effective Date of Coverage: ____________________ Termination Date: ____________________

Benefits Provided: Medical: Yes No Prescription: Yes No Dental: Yes No Vision: Yes No

**The Birthday Rule is a coordination of benefits rule that some plans use to determine which coverage is primary.*

### Acknowledgement

*If married, both the Participant and Spouse must sign below.*

I understand that it is my responsibility to immediately notify BAC Local Union 15 Welfare Fund (The Fund) of any changes in the above information. I understand that if I or my dependents provide false information to The Fund, we could be subject to severe penalties under state and federal law and The Fund may seek to recover benefits wrongfully paid or pursue legal remedies against us. I declare under penalty of perjury that the forgoing is true and correct.

## AUTHORIZATION

I agree, for myself and my dependents, that in the event any health services provided are the primary responsibility of any other party by way of other group health coverage or by the act of omission of another person to fully inform The Fund and that I will execute such assignments, liens or other documents which may be necessary to enable The Fund to recover the value of benefits provided. I further agree that in the event I or any of my dependents collect benefits or damages from any other party who has primary responsibility for services provided, I will immediately reimburse The Fund to the extent of services provided and to the extent as specified by the plan. **FRAUD WARNING:** Any person who, knowingly and with intent to defraud the Fund or other person: (1) files an application for benefits or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits, a fraudulent act and may be subject legal action

____________________ ____________________
Participant's Signature Date

____________________ ____________________
Spouse's Signature Date

FOR INTERNAL USE ONLY
MC REC:________BC REC:________DD REC:________REQ ON:________BY: ________