*220 S 27th St #B * Tacoma WA 98402*
(253) 474-1214 or (800) 223-2449
Fax: (253) 474-7180
E-mail: staff@unitedemployees.org
Website: www.unitedemployees.org

REQUEST FOR DUPLICATION INSURANCE INFORMATION

Insured Name: ______________________________

Insured Group#: ______________________________

Insured ID#: ______________________________

If you have coverage with another insurance, one carrier has "primary" responsibility for benefits and pays all of its benefits first. The other insurance will be "secondary" and will pay benefits on the balance left so that the total payment will not exceed 100% of the amount billed.

The Trust coordinates the payment of benefits with other group medical plans that you may have so that you receive the most complete coverage possible form the Trust.

To help us coordinate benefits and determine which carrier is primary and which is secondary, please complete all of the information requested below.

Name of other insured: ______________________________

Relation: ____________ SSN: ______________ Date of Birth: ______________

Employer: ______________________________ Date of Employment: __________

Insurance Company: ______________________________

Insurance Phone #: ______________________________

ID#: ____________________ Group#: ____________________

Effective Date of Coverage: ______________ Family Coverage: ☐ Yes ☐ No

Type of Coverage: ☐ Medical ☐ Prescription ☐ Dental ☐ Vision

If there is more than one insurance company, please complete a second form.