

# Sheet Metal Workers' Local 265 Welfare Fund

205 Alexandra Way

Carol Stream, IL 60188-2080

Telephone 630 668-7260

Fax 630 668-7338

Dear Participant,

We have received information regarding your coverage under the Local 265 Welfare Fund. We find that some additional information is needed to complete our records, or we need a routine update.

Please complete the information requested at the bottom of this letter and return in the enclosed pre-addressed envelope. (If you need more room, please write the answers on the back of this letter).

Thank you for your cooperation.

Sincerely,

Benefit Fund Office

1. Are you the insured under any other group insurance coverage or Medicare? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Is your spouse currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what is the name and address of your spouse's employer?

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3. Does your spouse have any other group insurance coverage or Medicare? Yes \_\_\_\_\_ No \_\_\_\_\_
  4. Is any other dependent covered under another group insurance or Medicare? Yes \_\_\_\_\_ No \_\_\_\_\_
  5. If yes to question 1, 3 or 4, please furnish the following information about the other insurance coverage:

- ◆ The name, address & phone # of the other insurance carrier:

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- ◆ Who is the member of that plan & who is covered under that plan: \_\_\_\_\_

- ◆ What type of coverage does that plan provide? (Medical, Dental, Vision) \_\_\_\_\_

- ◆ When did that plan become effective? \_\_\_\_\_

- ◆ The other insurance plan's group and ID#: \_\_\_\_\_

- ◆ Please submit a copy of the other insurance ID card.

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Local 265 Member's Name (Please print)

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Member's ID Number

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Member's Signature

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Date