OTHER INSURANCE QUESTIONNAIRE

INTERNATIONAL ALLIANCE OF THEATRICAL STAGE EMPLOYEES (I.A.T.S.E.) LOCAL 6
FRINGE BENEFIT FUNDS
6405 Metcalf, Suite 200 ● Overland Park, Kansas 66202
(913) 236-5490 ● Fax: (913) 236-5499● Email: OP-Claims@tici.com

Please fill out the information in the sections below completely. This information will assist us in providing your correct information to the IATSE Local 6 Profit Sharing Plan Record Keeper and will be needed if you have sufficient contributions made on your behalf to become eligible for Health Care benefits.

SECTION A. - MEMBER INFORMATION – PLEASE PRINT CLEARLY IN INK

LAST NAME	FIRST NAME	MIDDLE NAME	ID NUMBER
DATE OF BIRTH	GENDER ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ SINGLE ☐ DIVORCED ☐ WIDOWED ☐ MARRIED, LIST DATE OF MARRIAGE / /	SOCIAL SECURITY NUMBER
HOME ADDRESS	CITY	STATE	ZIP
HOME PHONE ( )	CELL PHONE ( )		
DO YOU HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO	IF YES, COVERAGE TYPE ☐ MEDICAL ☐ DENTAL ☐ VISION; POLICY TYPE ☐ ACTIVE ☐ RETIREE ☐ COBRA	EFFECTIVE DATE OF OTHER INSURANCE COVERAGE / /	TERMINATION DATE OF OTHER INSURANCE COVERAGE / /
NAME OF PLAN	PHONE NUMBER OF PLAN ( )		
ARE YOU ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO	IF YES, IS IT DUE TO ☐ END-STAGE RENAL DISEASE AND / OR ☐ DISABILITY		
IF YES, WHEN? / /	PART A EFFECTIVE DATE / /	PART B EFFECTIVE DATE / /	PART D EFFECTIVE DATE / /

NOTE: UNLESS YOU HAVE ALREADY PROVIDED DOCUMENTATION TO THE FUND OFFICE, YOU WILL NEED TO PROVIDE A COPY OF YOUR MARRIAGE CERTIFICATE

SECTION B. SPOUSE INFORMATION – (IF APPLICABLE)

LAST NAME	FIRST NAME	MIDDLE NAME	SOCIAL SECURITY NUMBER		
DATE OF BIRTH	HOME ADDRESS	CITY	STATE	ZIP	HOME PHONE ( )
DO YOU HAVE OTHER INSURANCE COVERAGE? ☐ YES ☐ NO	IF YES, COVERAGE TYPE ☐ MEDICAL ☐ DENTAL ☐ VISION; POLICY TYPE ☐ ACTIVE ☐ RETIREE ☐ COBRA	EFFECTIVE DATE OF OTHER INSURANCE COVERAGE / /	TERMINATION DATE OF OTHER INSURANCE COVERAGE / /		
NAME OF PLAN	PHONE NUMBER OF PLAN ( )				
ARE YOU ELIGIBLE FOR MEDICARE? ☐ YES ☐ NO	IF YES, IS IT DUE TO ☐ END-STAGE RENAL DISEASE AND / OR ☐ DISABILITY				
IF YES, WHEN? / /	PART A EFFECTIVE DATE / /	PART B EFFECTIVE DATE / /	PART D EFFECTIVE DATE / /		

SECTION C. CERTIFICATION AND SIGNATURE

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO IMMEDIATELY NOTIFY THE FUND OFFICE OF ANY CHANGES IN THE ABOVE INFORMATION. I HEREBY DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS CORRECT AND COMPLETE TO THE BEST OF MY KNOWLEDGE. TO ENSURE WE HAVE THE CORRECT NUMBER IN THE EVENT WE NEED TO CONTACT YOU, PLEASE PROVIDE A DAYTIME PHONE NUMBER WHERE YOU CAN BE REACHED BETWEEN 8:00 AM AND 5:00PM, MONDAY THROUGH FRIDAY.

PRINT NAME	DAYTIME PHONE ( )
MEMBER SIGNATURE	
PRINT NAME	DAYTIME PHONE ( )
SPOUSE SIGNATURE	

PLEASE RETURN THIS FORM AND COPIES OF ALL OTHER INSURANCE CARDS, IF POSSIBLE TO THE FUND OFFICE:

I.A.T.S.E. Local 6 Fringe Benefits Fund

6405 Metcalf, Suite 200
Overland Park, Kansas 66202
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REV 6/23/2020