PLUMBERS, PIPE FITTERS & MES
LOCAL UNION NO. 392
HEALTH & WELFARE FUND
1228 CENTRAL PARKWAY, ROOM 100
CINCINNATI, OH 45202
PHONE 513-241-0444

DEPENDENT INSURANCE VERIFICATION

Member Name:_____

Patient Name:_____

In order to process the claim for your dependent, we will need the following information:

Is your dependent covered by any other group insurance (i.e. employer, spouse, parent, step-parent, etc.)? _____ Yes _____ No

If yes, please complete the following:

Policyholder: _____

Name and address of insurance company:_____

_____

Group name and/or group number:_____

Policy number:_____

Customer service phone number:_____

I certify that the above information is true and correct.

_____ _____

Date Employee Signature