TEAMSTERS CALIFORNIA STATE COUNCIL
OF CANNERY AND FOOD PROCESSING UNIONS

PRODUCERS ALLIANCE
OF CALIFORNIA

JOINT BENEFIT TRUST
ADMINISTRATOR
4160 Dublin Blvd., Suite 400
Dublin, California 94568-7756
PHONE: (925) 833-7300
FAX: (925) 833-7301

CHAIRMAN, Maria Ashley Alvarado
CO-CHAIRMAN, Stacey Cue

DUAL COVERAGE QUESTIONNAIRE

Member: ______________________________ Date: ________________________

Member's S.S.# or JBT ID#: ________________ Patient: ______________________
(See Enclosed Information)

Dear JBT Member:

PLEASE COMPLETE ALL QUESTIONS

We are in receipt of a claim submitted for your dependent. Due to state laws with respect to coordination of benefits for dependent children, it is necessary to ask the following questions in order to determine the primary carrier for your dependent child. ***(See enclosed information).***

1. Provide birth date of both parents:
   Mother: mo.___ day___ year___ Father: mo.___ day___ year___
2. Does child live with both natural parents? Yes ☐ No ☐
3. If parents are divorced or separated, which parent has custody? Mother ☐ Father ☐
4. If divorced, is it written in your divorce decree that either parent is responsible for all health expenses for this child? Yes ☐ No ☐ If yes, which parent is responsible? Describe that responsibility or provide a copy of that portion of the divorce decree which explains the responsibility:
   ____
   ____
5. Please provide the following information regarding insurance coverage (other than JBT) for this child. If more room is needed, please use other side of this form.

- Name of other insured person: ______________________________
- Is insured working? ____________________ Retired? ____________________
- Relationship to patient (mother, father, stepparent): ______________________
- Other insured's Social Security # : ______________________________
- Name and address of other insured's employer: ______________________
  ____
- Effective date of coverage: ________________________POLICY # ______________
- If terminated, give date of termination: ______________________________
- Name, address and phone number of other group carrier: ____________________
  ____
- **MEDICAL: YES or NO DENTAL YES or NO**
- Does this policy include your dependents for coverage? ______________________
- **IS THIS AN HMO?** _____ **PPO?** ___ **EPO?** ____ **Chiropractic Coverage included**? ________

The charges submitted cannot be processed without this information. If you have any questions, please feel free to contact this office. Please return all enclosures with this completed form.