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

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 which indicates that you, or one of your family members, have other coverage through another carrier. Due to this coordination of benefits, it is necessary that the following information be provided in order for us to determine the primary carrier.

1) Please provide the following information regarding insurance coverage (other than JBT). If more room is needed, please use other side of this form.

- Name of other insured person: _____
- Is other insured working / Retired? _____
- If retired, date of retirement: _____
- Relationship to patient: _____

Other insured's social security number: _____

Birth date of insured: _____

2) Is other insurance coverage a group or private policy: _____

3) If other insurance is a group policy, please complete the following:

Name and address of other insured's group carrier:_____

_____

Subscriber: _____

Policy No.:_____Effective date of coverage:_____

MEDICAL: YES or NO DENTAL YES or NO

Termination date of coverage:_____

Does insurance cover your dependents?_____

- **IS THIS AN HMO ?** _____ **PPO?** ___ **EPO?** ___ C**hiropractic Coverage included**? _____

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

Sincerely,

Medical Eligibility Department