WEA trust
45 Nob Hill Road | Madison, Wisconsin 53713-3959
800.279.4000 WEAtrust.com

Dear WEA Trust Member:

Coordination of Benefits Request

When a member has more than one insurance policy, including Medicare, we are required by law to coordinate benefits. **If you have no other insurance, please disregard this form**.

We will need additional information from you in order for us to properly coordinate your benefits if any of the following apply:

- You or your dependents have other health or prescription drug insurance, including Medicare or military insurance.
- A divorce decree or court order specifies which parent is responsible for a child's medical expenses.

If you answer yes to **any** of these questions, or if **any** of your other health insurance information has changed, please complete and return the form on the reverse side with any supporting documents to us at the address below.

WEA Trust Insurance
P.O. Box 21538
Eagan, MN 55121

If you prefer, you can provide the information to our Customer Service Department at (800) 279-4000 or fax it to (608) 276-9119.

We appreciate your prompt attention to this matter.

Sincerely,

Customer Service Department

WEA Trust Policy Holder Name:	Policy Holder No.:	Group No.:

Answer **all** questions.

1. Do you or your dependents have **other health insurance**? **Including:** Medicare, military insurance, and ANY other WEA Trust plans (school, state, local)?

   ☐ No
   ☐ Yes (Go to Section 1 if you have other health insurance. Go to Section 2 if you have Medicare.)

2. Do you have a divorce decree that affects insurance for dependent children under your WEA Trust policy?

   ☐ No
   ☐ Yes (Send a copy of the part of the divorce decree that talks about health insurance.)

Section 1: Other Health Insurance-Send copies of other insurance cards (not your WEA Trust insurance card)

Name of Policy Holder	
Date of birth for this Policy Holder:	
Name and phone number of other insurance:	
Date the insurance started: Date the insurance terminated, if applicable.	
Policy/Group number:	
Is the other insurance from an employer? If yes, name of employer: If yes, names of family members covered:	☐ Yes ☐ No
Is other insurance Medicare Supplement?	☐ Yes ☐ No
Is this a retiree plan?	☐ Yes ☐ No

Section 2: Medicare-Send copies of Medicare cards.

Your Medicare identification number:	**Family members with Medicare** Family member name(s): Medicare identification number(s):
Do you have Medicare hospital insurance (Part A)? ☐ Yes ☐ No If yes, date it started:	Does your family member have Medicare hospital insurance (Part A)? ☐ Yes ☐ No If yes, date it started:
Do you have Medicare health insurance (Part B)? ☐ Yes ☐ No If yes, date it started:	Does your family member have Medicare health insurance (Part B)? ☐ Yes ☐ No If yes, date it started:
Are you actively employed? Yes No	Is your family member actively employed? Yes No

I confirm that the information on this form is correct and true.

Policy Holder Signature _____ Date _____