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 above.

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

Subscriber Name:	Subscriber No.:	Group No.:

Please answer all questions and provide all requested information. Sign and date the completed form and return it to the WEA Trust.

1. Are you and/or any of your covered family members eligible for Medicare or insured by any other health insurance, including military insurance or ANY other WEA Trust plans (school, state, local)?

   ☐ No
   ☐ Yes If yes, please provide additional information about the other health insurance and/or Medicare in the appropriate section(s) of the form below.

2. Does a divorce decree affect insurance coverage for any dependent children covered by your WEA Trust policy?

   ☐ No
   ☐ Yes If yes, please send a copy of the portion of the divorce decree that stipulates health insurance coverage.

Section 1: Other Health Insurance (Please send copy of all insurance cards, other than the WEA Trust.)

Name of subscriber to other health insurance: _____ Date of Birth: _____

	Other Health Insurance
Other Insurance name/phone number	
Effective date	
Policy/group number	
Is this coverage from an employer? If yes, name of employer:	☐ Yes ☐ No
If coverage is from an employer, please list names of family members with this other insurance coverage.	
Is this a retiree plan?	☐ Yes ☐ No

Section 2: Medicare (Please send copy of Medicare cards.)

Your Medicare identification number:	Name(s) of family member(s) with Medicare: Medicare identification number(s):
Are you enrolled in Medicare hospital insurance (Part A)? ☐ Yes ☐No If yes, effective date:	Is this person enrolled in Medicare hospital insurance (Part A)? ☐ Yes ☐No If yes, effective date:
Are you enrolled in Medicare health insurance (Part B)? ☐ Yes ☐No If yes, effective date:	Is this person enrolled in Medicare health insurance (Part B)? ☐ Yes ☐No If yes, effective date:
Are you actively employed? ☐ Yes ☐No	Is this person actively employed? ☐ Yes ☐No

I acknowledge that the information I have provided on this form is accurate and complete.

Subscriber Signature _____ Date _____