ILWU-PMA BENEFIT PLANS /

International Longshore & Warehouse Union —
Pacific Maritime Association **www.benefitplans.org**

1188 FRANKLIN STREET • SUITE 101 • SAN FRANCISCO, CALIFORNIA 94109

PHONE (415) 673-8500
FAX (415) 749-1400

ILWU-PMA Pension Plan
ILWU-PMA Welfare Plan

ILWU-PMA Watchmen Pension Plan

October 29, 2024

To: ILWU Longshore, Ship Clerk, Walking Boss/Foreman, and Watchmen Locals

From: Mario Perez, Director of Benefit Plans

Subject: ILWU-PMA Welfare Plan - Coastwise Claims Office - Annual Other Insurance Coverage Verification Requirement

The attached letter and form will be mailed by the Coastwise Claims Office this week. In order to better receive and track requests for other insurance information, this is an annual mailing each year to collect the information. The mailing will be sent to all members. Members can fax, mail, or login to a secure website to complete and submit the information. Please encourage members to complete the process timely to avoid future claims processing delays. Members with Kaiser are also required to complete the process as the CCO processes their chiropractic claims.

Attachments.

cc: Area Welfare Directors

A copy of this memo can be downloaded at www.benefitplans.org.

ILWU-PMA Coastwise Claims Office
PO Box 429101
San Francisco, CA 94142
FAX # 415-646-4414

October 30, 2024

**** **REVISED CONTENT PLEASE READ CAREFULLY** ****

Please complete this form online using the link below

https://edge.zenith-american.com/

or if you prefer, you may return by fax or by mail in the enclosed envelope. If you do not return the enclosed form by December 31, 2024, claims for your dependents will be denied until this form is received.

Dear ILWU-PMA Welfare Plan Participant:

This Plan requires ALL members with covered dependents to complete an Other Insurance Coverage Form on an annual basis. Although you may be on Medicare or dual covered under the ILWU-PMA Welfare Plan, you are required to complete this form in order to process your medical claims correctly.

Additionally, there are a few other groups of people who need to provide information about other insurance, these include: **Surviving Spouses, Surviving Children, and Non-Medicare Retirees**.

People in the above groups may have additional insurance which could be considered primary to their ILWU-PMA Welfare Plan coverage. In order to properly coordinate benefits, the Coastwise Claims Office must know the details of your **OTHER** insurance. **This is any insurance that you, your spouse or dependents may have that would be in addition to the insurance you have through ILWU-PMA.**

Even if you have provided this information earlier in the year, you are still required to submit the enclosed form to avoid any delay in your family's medical claims. In order to provide current information to the Plan please see the instructions below:

The quickest, most efficient way to respond is by going to the link below. Log in to the secure site and complete the form online. The secure site is called Participant Edge, Zenith American Solutions Portals (see link below). On the Home page, click on LOGIN and select "Participant Edge". This will allow you to register as a first-time user or welcome you back if you have registered in the past. On the left side, click on "other insurance", then you will see a blue box on the right that states, "start update". Click on that blue box and follow the prompts to provide the required information. You must provide an update for each person covered on your plan. Once completed you will confirm your electronic signature and get a reference number for your records. Below the box for "Other Insurance" you can click on Contact us to send us an email for any additional questions or concerns.

https://edge.zenith-american.com/

- **CIP members in WA/OR enter the number on your insurance card under Participant ID in the Alternate ID field**
- **CIP members in CA enter the number on your card under Participant ID, minus the WUE, in the Alternate ID field**
- **Kaiser members enter the number on your Chiro card under Member ID into the Alternate ID field**
- **If you DO NOT yet have an ID card, you will need to call us for your ID number or just return the form by mail or fax – and enter your longshore registration number in the Welfare ID box.**

If you do not have access to a computer, you may complete the enclosed form and send via:

Fax to (415) 646-4414 OR mail using the enclosed pre-paid addressed envelope

If you have any questions or need assistance with this process, please contact the Coastwise Claims Customer Service Office at (800) 955-7376.

ILWU-PMA WELFARE PLAN – OTHER INSURANCE VERIFICATION FORM

Complete, Sign and Return Before December 31, 2024

YOU ARE REQUIRED TO FILL OUT THIS FORM AND RETURN IT. IF YOU DO NOT RETURN THIS FORM COMPLETED BY THE DATE INDICATED ABOVE, YOUR SPOUSE'S AND/OR DEPENDENTS' CLAIMS WILL BE DENIED UNTIL THE FORM IS RETURNED

PART A: YOUR INFORMATION

LAST NAME:	FIRST NAME:	M.I.:	WELFARE ID/REGISTRATION NO:	DATE OF BIRTH:	
HOME ADDRESS:			CITY:	STATE:	ZIP CODE:

TELEPHONE:	MARITAL STATUS		DO YOU HAVE ANY INSURANCE OTHER THAN ILWU MEDICAL INSURANCE? (MEDICAID, MEDICARE, RETIREE, STUDENT, PRIVATE, ETC.)	
	WIDOW ☐	MARRIED ☐	NO ☐	YES ☐
	DIVORCED ☐	SEPARATED ☐	INSURANCE NAME:	PHONE NUMBER:
	IF DIVORCED, DATE OF DIVORCE:	SINGLE ☐	POLICY NUMBER:	EFFECTIVE DATE:

PART B: YOUR DEPENDENT INFORMATION [SPOUSE AND/OR CHILDREN]; DO ANY OF YOUR DEPENDENTS HAVE ANY OTHER MEDICAL INSURANCE? (MEDICAID, MEDICARE, RETIREE, STUDENT, PRIVATE, ILWU-PMA, ETC.)

PLEASE ENTER INFORMATION FOR EACH DEPENDENT

Dependent Type	Other Insurance		Full Name	Birthdate	Other Insurance Company Name	Tel. No.	Policy No.	Eff. Date
Spouse	YES ☐	NO ☐						
Child/Other	YES ☐	NO ☐						
Child/Other	YES ☐	NO ☐						
Child/Other	YES ☐	NO ☐						
Child/Other	YES ☐	NO ☐						
Child/Other	YES ☐	NO ☐						
Child/Other	YES ☐	NO ☐						
Child/Other	YES ☐	NO ☐						
Child/Other	YES ☐	NO ☐						
Child/Other	YES ☐	NO ☐						

CONSENT INFORMATION

By my signature below, I acknowledge that the ILWU-PMA Coastwise Claims Office and its authorized agents may use and disclose health information for purposes related to evaluating, processing, and reviewing my claims or my dependent's claims, and I consent to the disclosure of information requested by the ILWU-PMA Coastwise Claims Office, by any medical professional, hospital or other medical-care institution, insurance support organization, pharmacy, governmental agency, insurance company, group policy holder, employer or benefit plan administrator. This consent will be valid for the entire period of my eligibility and my dependent's eligibility under the Plan. I hereby certify that all information provided on this form is accurate and complete to the best of my knowledge.

ILWU-PMA Covered Employee Signature:	Date:

COMPLETE, SIGN AND RETURN FORM TO: ILWU-PMA Coastwise Claims Office
PO Box 429101, San Francisco, CA 94142 FAX: 1-415-646-4414