ALLIED PILOTS ASSOCIATION INSURANCE VERIFICATION FORM

Return completed form to:
Allied Pilots Association
14600 Trinity Blvd. Suite 500
Fort Worth, TX 76155
Phone: 817-302-2140
Fax: 817-302-2149
Email: benefits-forms@alliedpilots.org

Please complete this form in order for your plan ID cards to be issued & claims processed appropriately.

Verification of Medicare and/or Other Group Health Coverage

Please complete this form by answering each question below. **Please send a copy of your ID cards (Medicare, Part D or OGHC card).** Please sign, date & return this form to APA Benefits for timely processing of your claims.

Member Name: (Please print)	Employee Number: (Please print)
Spouse Name: (Please print)	Dependent(s) Name: (Please print)
Effective date of contribution change for SMP:	
Is the member covered under any other group health plan?	Yes ☐ No ☐
If yes, please provide the name of the other group health plan: Effective date of the other health plan:	
Is *member* using SMP as *primary* medical coverage?	Yes ☐ No ☐
Is your spouse or dependent(s) covered under any other group health plan?	Yes ☐ No ☐
If yes, please provide the name of the other group health plan & spouse name or dependent(s) covered: Effective date of the other group health plan:	
Is your *spouse* using SMP as *primary* medical coverage?	Yes ☐ No ☐
Is your *dependent(s)* using SMP as *primary* medical coverage?	Yes ☐ No ☐
Is the member or spouse eligible for Medicare?	Member ☐ Spouse ☐
If yes, complete the following: Medicare Part A (Hospital Insurance Benefits) Medicare Part B (Medical Insurance Benefits) Medicare Part D (Prescription Drug Coverage)	Member / Spouse Effective Date: Effective Date: Effective Date:

Signature: Date:

I hereby authorize WebTPA to adjust my contributions based on the information provided on this form & in accordance with the Plan guidelines. I understand that contributions draft, via ACH, on or about the 25th of each month.