BAY AREA AUTOMOTIVE GROUP WELFARE FUND
4160 Dublin Blvd., Suite 400
Dublin, California 94568-7756
Telephone 1-800-267-3232 ● Fax 925-833-7301

Member: _____ Date: _____

Member's S.S.# or BAAG ID# _____ Patient: _____
(See Enclosed Information)

Dear BAAG 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 BAAG). 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: _____

   Birthdate 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: _____

   Termination date of coverage: _____

   Does insurance cover your dependents? _____

   Is this an HMO plan? _____

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