1901 Las Vegas Blvd. So. Suite 107
Las Vegas, Nevada 89104-1309
(702) 733-9938
www.culinaryhealthfund.org

OTHER HEALTH INSURANCE VERIFICATION

Participant Name : _____

Address : _____

City, State Zip Code: _____

Re: Verification of Spouse's Health Insurance Information
Participant ID: _____
Patient Name: _____

You MUST respond to the inquiries below. If you **do not** respond, we will **not** pay for your claims until a response has been received.

Is the patient employed? ☐ **NO** ☐ **YES** – If YES, please provide the name of the employer your spouse works for.

Employer's Name: _____

Is the patient Self-Employed? ☐ **NO** ☐ **YES**

Is the patient a retiree? ☐**NO** ☐**YES** – If YES, is insurance offered through retirement? ☐**NO** ☐**YES** – Please complete Section 1A below

Is the patient covered by Medicare or Medicaid? ☐**NO** ☐**YES** – by ☐Medicare ☐Medicaid– Please complete Section 1A below

IS THE PATIENT COVERED BY HIS/HER EMPLOYER'S HEALTH PLAN? ☐ **YES, COMPLETE SECTION 1A.** ☐ **NO, COMPLETE SECTION 1B.**	
1A. If YES, please indicate: Insurance Name: _____ Address: _____ Phone No: _____ Policy Number: _____ Effective Date: _____ **Insurance type -** Check all that apply: ☐ Single ☐ Family ☐ Medical ☐ Dental ☐ Vision	**1B. If NO, please provide reason:** ☐ Insurance is not offered ☐ Part Time Employee – not eligible for health benefits ☐ Spouse is eligible but not signed up ☐ New employee, will be eligible in _____ (month/year)

Participant signature: _____ *Date:* _____

Let us know if you have any questions or need help. You can call our Customer Service Office at (702) 733-9938.

Sincerely,
Culinary Health Fund