



Proof of Other Coverage Form

Complete this form **ONLY IF** you elect the "Dual Income" option as your Medical Plan choice.
Attach a copy of the identification card from your other insurance coverage.

Please return this form to the Fund Office with your Choice Benefits Enrollment Form.

My other medical coverage is provided through:

Employer Name or Union Plan:

The Carrier is: (for example Blue Cross/Blue Shield):

Policy Number:

Your Waiver and Authorization

By signing this form, I am electing the Dual Income option for medical coverage, waiving my right to any other medical plan coverage under the Fund, and certify that I have the medical coverage indicated above.

Your signature:

Spouse's signature:

Date:

Please print name:

Social Security Number:

Store Name and Number
