FIVE RIVERS CARPENTERS HEALTH & WELFARE FUND
C/O EASTERN IOWA FRINGE BENEFIT FUNDS, INC
5001 J STREET SW, SUITE 100
CEDAR RAPIDS IA 52404
319-366-3623
1-800-847-0113
FAX: 319-362-7272

OTHER INSURANCE INQUIRY

1. Are you, your spouse or any other dependent covered by:

   (a) Other insurance or medical service? (Individual plans are not included.)
   _____Yes _____No (If "Yes," complete 2, 3 and 4.)

   (b) Other vision coverage?
   _____Yes _____No (If "Yes," complete 2, 3 and 4.)

   (c) Other dental coverage?
   _____Yes _____No (If "Yes," complete 2, 3 and 4.)

2. Full name of any family member who is covered under other group coverage.

   _____

3. Name of the health and welfare fund or insurance company.

   _____

   Other insurance policy number.
   _____

   Effective Date _____
   Termination Date _____ (Please provide a copy of the HIPAA Certificate)

   Employer's name and address.

   _____

   _____

   Other Insured's membership or Social Security or
   Other identifying number.

   _____

   Spouse's date of birth

   _____

4. Other insurance covers:
   _____Insured only _____Insured and spouse only
   _____Children only _____Insured and family
   _____Insured and children only

Please use a separate sheet of paper to provide any other information which will assist us in the handling of your claims.

I/We certify that the above information is true and correct, and authorize any union, trust fund, employer, insurance carrier, physician or hospital to furnish information to the insurance company about any other benefits to which I/We may be entitled.

Insured's Signature — Print Name (Clearly)

Date — Participant's Social Security Number