Date: __________________

Name: ______________________
Address: ___________________________
____

Dear Insured,

Information received in our office indicates you and/or your family member may have other health insurance coverage.

Before benefits can be considered it is necessary to determine whether Tongass Timber Trust should be the first payer or the secondary payer for benefits. Please see the Tongass Timber Trust Summary Plan Description for an explanation of coordination of benefits and order of benefit determination.

Please answer the following questions regarding other health coverage.

1. List the individuals who are eligible for benefits under your family's other insurance coverage: ____
____

2. Coverage under the other policy began as of _______________ and provides the following coverages: Medical __________ Dental __________ Vision __________

3. If coverage for any of the above named individual(s) ceased, please advise the date the coverage ended and the name of the family member: ______________________
____

Signed: _______________________________________ Date: ______________________
Insured TTT participant

Please return this information as soon as possible to insure prompt processing of your claims. Thank you for your assistance in this matter.