



HEALTH PLANS

Live better. Save more.



Other Insurance Information

Subscriber Name: _____

Subscriber Identification Number: _____

1) Does any member covered on this policy have other medical or dental insurance?
() YES () NO

2) If "YES" complete the information below:

Name of member covered by other insurance: _____
Employer: _____
Insurance Company: _____
Effective Date of Coverage: _____
Policy Holder: _____
Contract/ID#: _____
Coverage type: () Family () Individual () Retired

3) Is any member covered under your policy also eligible for Medicare?
() YES () NO

If "YES" complete the questions below:
Effective date: _____
Are they covered by Part A: () YES () NO
Are they covered by Part B: () YES () NO
Are they disabled? () YES () NO
Do they have ESRD? () YES () NO

4) Do you have a dependent child 18 years or older? () YES () NO

If "YES" complete questions below:
Are they married? () YES () NO
Do you provide 51% of support? () YES
Is the dependent a full-time student? () YES () NO
If "YES" complete: Names of Student(s): _____
Name of School(s): _____

5) Is any family member covered by the court decree? () YES () NO

If "YES" complete: Name(s) of child or children: _____
Responsible Party(ies): _____

I certify to the best of my knowledge, the information provided above is true and correct.

Subscriber Signature

Date