

Your health benefit plan contains a coordination of benefits provision in which we must determine who has primary coverage for your covered dependent(s), when one or more coverages are in effect. Once this information is obtained, we will be able to process any claims in question in a prompt and precise manner.

Other Insurance Information

We ask that you complete the following:

- Do you have Medicare coverage? _____ No _____ Yes
If yes, what is the effective date? _____

- Does your spouse have Medicare coverage? _____ No _____ Yes
If yes, what is the effective date? _____

- Is your spouse employed? _____ No _____ Yes
If yes, what is the name of Employer? _____
Address of Employer: _____

- Do you or any of your dependents have other insurance coverage?
_____ No _____ Yes
If yes, please list each individual with other coverage below:
Name of Individual: _____
Policy or Group Name: _____
Insurance Company Name: _____
Address for Claims: _____

Please indicate type(s) of coverage:
Medical _____ Dental _____ Vision _____ Hearing _____

Please attach a copy of your Medicare or other insurance card.

Employee Signature: _____
Date: _____