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OTHER COVERAGE

A. Complete for Employee Only

1. Are you covered by any other insurance?

☐ Yes – As the policy holder OR ☐ Yes – As a dependent. Please continue with Section A

☐ No – Skip to B. Spouse / Dependent(s) section.

Policy Holder's Name **Date of Birth** **ID Number**

_____ ____/____/____ _____

Insurance Carrier's Name **Address** **City/State/ZIP** **Phone Number**

_____

Effective Date of Coverage: ____/____/____ Termination Date (if applicable): ____/____/____

If you are the policy holder for this other coverage, please list the names of Eligible Dependents covered under the above carrier:

_____ _____

_____ _____

Please check all insurance types that apply: ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy

Policy Holder's legal relationship to Eligible Dependents:

☐ Spouse ☐ Mother ☐ Father ☐ Step-Parent ☐ Legal Guardian ☐ Other: _____

2. Do you have this coverage due to other employment?

☐ Yes, for myself OR ☐ Yes, for my spouse – Please continue with Section A

☐ No – Skip to B. Spouse / Dependent(s) section

Employer's Name **Address** **City/State/ZIP** **Phone Number**

_____

3. Hire date with this other employer: _____

4. Effective date of coverage with this other employer: _____

5. Please check the type(s) of coverage you have with this other employer:

☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy ☐ Retiree ☐ Other: _____

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B. Complete for Spouse / Dependent(s)

6. Is/are your spouse and/or dependent(s) **eligible** for employer sponsored coverage through another insurance carrier? ☐ Yes ☐ No

7. Is/are your spouse and/or dependent(s) **covered** by other insurance? ☐ Yes ☐ No

Policy Holder's Name	Date of Birth	ID Number
_____	____/____/____	_____

Employer's Name	Address	City/State/ZIP	Phone Number

Insurance Carrier's Name	Address	City/State/ZIP	Phone Number

Effective Date of Coverage: ____/____/____ Termination Date (if applicable): ____/____/____
Names of Eligible Dependents covered under the above carrier:

_____ _____

_____ _____

Please check all insurance types that apply: ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy

Policy Holder's legal relationship to Eligible Dependents:
☐ Spouse ☐ Mother ☐ Father ☐ Step-Parent ☐ Legal Guardian ☐ Other: _____

C. Complete for All Covered Persons

8. Does Medicare/Medicaid apply to any family member? ☐ Yes (List names below) ☐ No

Name(s): _____

Please check all coverage types that apply.

☐ End Stage Renal Disease	Effective Date: ____/____/____	Termination Date: ____/____/____
☐ Disability	Effective Date: ____/____/____	Termination Date: ____/____/____
☐ Medicare Aged	Effective Date: ____/____/____	Termination Date: ____/____/____
☐ Medicare Part A	Effective Date: ____/____/____	Termination Date: ____/____/____
☐ Medicare Part B	Effective Date: ____/____/____	Termination Date: ____/____/____
☐ Medicare Part D	Effective Date: ____/____/____	Termination Date: ____/____/____

Signature: _____ **Date:** ____/____/____

Please print name here: _____

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