



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 you answered "YES" to question No. 1, complete the information below:

Name of member covered by other insurance: _____

Employer: _____

Insurance Company: _____

Insurance Company Telephone Number: _____

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:

_____ Name Medicare ID Date of Birth

Please check all that apply:	Yes/No	Effective Date	Termination Date
<input type="checkbox"/> Medicare Part A			
<input type="checkbox"/> Medicare Part B			
<input type="checkbox"/> Medicare Part C			
<input type="checkbox"/> Medicare Part D			

Are they disabled? () YES () NO

Do they have End Stage Renal Disease (ESRD)? () YES () NO

4) Is any family member covered by a 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