

Enrollee's Other Health Plan Coverage

Instructions

Provide the coverage information for each family member covered under your health plan.

You'll need to submit to _____.

Section 1: Health plan information

Relationship	Name	Date of Birth (DOB)	Covered by another plan?
Self (Primary subscriber)			<input type="checkbox"/> Yes <input type="checkbox"/> No
Spouse			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent			<input type="checkbox"/> Yes <input type="checkbox"/> No
Dependent			<input type="checkbox"/> Yes <input type="checkbox"/> No

- If no one is covered by another plan, go to **Section 4** to sign and submit the form.
- If anyone has another plan, complete **Section 2**. Also complete **Section 3** if there's Medicare coverage.
- If there is more than one additional plan, provide the information in a separate copy.

Section 2: Other health plan information (Including Medicaid/CHIP)

Primary subscriber name _____ Primary subscriber DOB _____

Member ID / policy number (Include letters) _____ Group number _____

Health plan name _____ Health plan address _____

City _____ State _____ ZIP _____

Health plan phone number _____ Coverage start date _____ Coverage end date _____

Employer name _____ Subscriber is: Active Retired on COBRA

Plan is: Group Individual Supplemental Tricare

List each person covered by this plan:

Spouse _____ Dependent _____

Dependent _____ Dependent _____

Dependent _____ Dependent _____

A. If the other plan covers a child, provide:

Mother's name _____ DOB _____ Father's name _____ DOB _____

B. If parents are separated, divorced, or not married, list:

Child resides with _____ Relationship _____

Individual with custody _____ Relationship _____

C. Is there a court order establishing responsibility for health care coverage?

No Yes

If yes, provide the following: Responsible party _____ Relationship _____

If multiple children have coverage under another plan — and the information above is different, provide in a separate copy.

Section 3: Medicare coverage information

Medicare subscriber name _____ Medicare ID number _____

• Part A – Effective date _____

• Part B – Effective date _____

• Entitlement reason:

Age

Disability

End stage renal disease

○ If due to end stage renal disease, provide the first date of dialysis _____

○ Home dialysis Facility or dialysis center

○ Date of kidney transplant, if applicable _____

Section 4: Signature

Name of person completing the form

Relationship to primary subscriber

Signature

Date