

# Other Insurance Information Inquiry Form

Subscriber name	Subscriber social security number	Subscriber phone number ( )
Subscriber address		
City	State	Zip
<input type="checkbox"/> Check here if this is a new address.		
Are you, your spouse or any of your dependents covered under any other Group Health Plan in addition to HealthPlus? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If your other coverage was cancelled, the cancellation date is: _____		
If you answered "No," please go to Section 1. Complete the questions and sign your name below.		
If you answered "Yes," please complete the entire form (Sections 1 and 2).		

### Section 1: To be completed by Subscriber

Spouse's first and last name	Spouse's social security number	Spouse's birth date	
Subscriber's signature	Today's date	Subscriber's phone number ( )	Subscriber's birth date

### Section 2: Other Group Health Plan information

Policyholder name	Social security number	Birth date	Sex	Relationship to Subscriber
Employer's name		Employer's address		
Employer's city	State	Zip		
Health care plan name		Health care plan phone number ( )		
Health plan city	State	Zip		
Pharmacy carrier	ID number	Effective date of coverage	Person is: <input type="checkbox"/> Active <input type="checkbox"/> Retired	
Type of coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family	Type of plan (check all that apply): <input type="checkbox"/> Hospital <input type="checkbox"/> Surgical/Medical <input type="checkbox"/> Prescription drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision			

Please list any other dependents covered by the other Group Health Plan. If there are more than four, please check this box  and list the rest on the back of this form.

1. First and last name	Relationship to Subscriber	3. First and last name	Relationship to Subscriber
2. First and last name	Relationship to Subscriber	4. First and last name	Relationship to Subscriber

If you have a child/children whose natural parents are divorced or separated, please attach a copy of the divorce decree or paternity order specifying responsibility for medical expenses.

Name of insured person responsible for child's coverage		Social security number	Birth date
Employer's name		Street address	State Zip
Name of health care plan		Street address	State Zip
Group/policy number	ID number	Effective date of coverage	
Type of coverage: <input type="checkbox"/> Single <input type="checkbox"/> Family	Type of plan (check all that apply): <input type="checkbox"/> Hospital <input type="checkbox"/> Surgical/Medical <input type="checkbox"/> Prescription drug <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
1. Child's first and last name		3. Child's first and last name	
2. Child's first and last name		4. Child's first and last name	

To the best of my knowledge, all statements are true and accurate.

Signature	Date
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