

OTHER INSURANCE INFORMATION

Subscriber's ID# _____ Subscriber's Name _____

TWO (2) BLUES? If yes, other ID# _____

OTHER INSURANCE: YES NO

Includes all family members: YES NO

If no, explain: _____

Employer: _____

Policyholder for other insurance: _____

Name/Address of other insurance: _____

ACTIVE POLICY RETIRED POLICY SINGLE POLICY FAMILY POLICY

ID#: _____ Group #: _____

Effective date: _____ Cancel Date: _____

Type of coverage: MEDICAL DRUG VISION DENTAL ALL

Birthday Rule: YES NO explain: _____

DIVORCE INFORMATION:

Children covered by natural father: YES NO Children covered by natural mother: YES NO

Name of other parent: _____

Insurance company: _____

Address of other insurance: _____

ID# _____ Group # _____

Type of coverage: MEDICAL DRUG VISION DENTAL ALL

Who is prime carrier: Divorce decree?/Parents name: _____ Custody?/Parents name: _____

MEDICARE INFORMATION: Subscriber's Medicare # _____

Med A effective date: _____ Med B effective date: _____

Spouse Medicare #: _____

Med A effective date: _____ Med B effective date: _____

OTHER:

Has any family member had other group coverage which has been terminated in the last two years: YES NO

If yes, complete items A-D: A. Name of carrier _____

B. Type of coverage: MEDICAL DENTAL BOTH

C. Effective date _____

D. Termination date _____

COMMENTS:
