Date: _____

RE: Employer: _____ Employee: _____

Claimant: _____ Last 4 digits of Employee's SSN: _____

Other Coverage Information Form

In order to update our reinsurance information files and to expedite the reimbursement process, please complete the form below and return it to me along with the attached work status form.

You may fax it to:_____ or you may email it to:_____ Date From:

_____ Date Through: _____

Has the employee or members of his/her family been covered under another group's insurance plan during the time period indicated above: ☐ Yes ☐ No (If no, please skip this section)

If yes, please complete the information below and state the dates the employee was covered:

Name and Date of Birth of Insured: _____ Dates Covered: _____

Name of Insurance Carrier: _____

Address of Insurance Carrier: _____

Insurance Policy Number: _____

Type of Plan: ☐ Medical ☐ Dental ☐ Both

Type of Coverage: ☐ Family ☐ Individual

Does this plan coordinate by Gender or Birthday rule? _____

If there is family coverage, please list family members covered under the plan: _____

_____

Is the employee or members of his/her family covered under Medicare? ☐ Yes ☐ No
(If no, please skip this section)

If yes, please check which Part's, list the effective date and provide a copy of the cards.

Part A ☐ Part B ☐ Effective Date: _____

Signature: _____ Date: _____

**********FORM MUST BE SIGNED BY EMPLOYEE**********

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