

Other Medical Coverage Questionnaire

Name: _____ Agreement #: _____

I () am () am not covered under another group plan

My dependents () are () are not covered under another group plan

If no other coverage exists, please complete Section 4 only. If any other coverage exists, please fill out the rest of this form.

Section 1

Insurance Company Name: _____

Policy #: _____ Phone #: _____

Medicare () Yes () No Effective Date: _____

Reason for Entitlement: _____

Social Security Number: _____ HIC #: _____

Section 2

List the name of all Family Members covered

Insured's Name _____ Birthdate _____

Spouse's Name _____ Birthdate _____

Dependent _____ Birthdate _____

Dependent _____ Birthdate _____

Section 3

Check types of expenses covered by the plan:

_____ Hospital Expenses

_____ Doctor Expenses

_____ Dental Expenses

_____ Drug Expenses

_____ Vision Expenses

_____ Medicare

Section 4

Please provide a phone number at which you can be reached during the day should we need to contact you.

Daytime Phone Number: _____

Signature: _____ Date: _____

Print Name: _____