

## SUBSCRIBER INFORMATION (Please Print Clearly or Type)

Subscriber Name: \_\_\_\_\_

ID Number: \_\_\_\_\_

## COVERAGE INFORMATION

**Please note: if you, your spouse or dependent(s) have:**

- Other coverage, please complete section 1, then sign and date the form.
- No other coverage, please complete section 2, then sign and date the form.

**1. Other Coverage (list each separately)**

Carrier Name: \_\_\_\_\_

Carrier Address: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Policy # \_\_\_\_\_ Subscriber's SS# \_\_\_\_\_

Policy Effective Dates: Start \_\_\_\_\_ End \_\_\_\_\_ Covered Dependents \_\_\_\_\_

**Coverage type:**

(Check applicable) Hospital \_\_\_ Major Medical \_\_\_ Prescription \_\_\_ Dental \_\_\_ Retiree \_\_\_ Cobra \_\_\_ Other \_\_\_

**2. No Other Coverage**

If your spouse does not have other health coverage, please indicate the reason:

Benefits not offered \_\_\_\_\_ Unemployed \_\_\_\_\_ Self-employed \_\_\_\_\_ Waived, as of: \_\_\_\_\_

Part-time employee (not eligible for benefits) \_\_\_\_\_

Other, please explain: \_\_\_\_\_

## SUBSCRIBER SIGNATURE

**I certify that the above information is correct and understand that I am obligated to provide this information accordance with the Plan Document. Failure to provide complete and accurate information may result in a delay in the processing of claims.**

Print Your Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_