Subscriber ID# _____

Group # _____

Dear Subscriber:

Your insurance contract has a coordination of benefits provision. This means that our payments and payments received from other group health coverage and / or certain government programs cannot exceed the total charges for covered services. As a service to your group, and in order to determine payable benefits, we periodically request information about whether you or any covered dependents have other group health coverage and / or are covered under government programs.

Are any members of this contract currently participating in any other health plan or government program? Please check one of the following (must choose one.)

(For AHCCCS or Champus, please select NO).

_____ If yes, please complete the questions on the next page.

_____ If no other insurance is available, please sign and date below.

If you have cancelled coverage with another insurance carrier, please complete the information on the next page and be sure to include the date your coverage ended.

CERTIFICATION: I certify that the information I have provided is a complete, true and correct record to the best of my knowledge.

Subscriber Signature: _____ Date: _____

Thank you for your cooperation