Secondary Insurance Information

SECTION I

Other group health care coverage information (other than group/ID listed on previous page)
Please list all additional group coverage if more than one plan/program applies. Please complete as thoroughly as possible.

Other Subscriber name: _____
Other Subscriber date of birth: _____
Insurance Company: _____
Address: _____
City/State/Zip: _____
Phone number: _____
Social Security number: _____
Group/Policy number: _____
Effective date: _____
Cancel date: _____

Employer's name: _____
Address: _____
City/State/Zip: _____
Phone number: _____

Type of Coverage:
Single ___ Family ___

Type of Plan:
Medical ___ Group ___
Dental ___ Individual ___

Employment Status:
Active ___ Retired/COBRA ___

List each dependent and their effective date

_____
_____
_____
_____

SECTION II

For dependent coverage, is there a divorce decree involved? Yes ___ No ___
If yes, does the divorce decree require one parent to provide primary health care coverage?
Yes ___ Please give name and relationship _____
No ___ Name and relationship or person with custody _____
If joint custody, Birth date of natural father: _____ Birth date of natural mother: _____
(This information is necessary to determine whose coverage will be the primary payer)

SECTION III

Are you or any covered dependent eligible for Medicare? Yes ___ No ___
If yes, please provide the Medicare beneficiary information:
Name of Beneficiary: _____ Employment Status: Active: ___
Retired: ___ Date retired: ___