Other Insurance Questionnaire

Employee Name ________________________ **Member ID #** ____________________________
Claim No. ________________________ **Incurred** ____________________________
Account No. ________________________ **Group No.** ____________________________

Do you or any of your covered dependents have other existing health coverage? Yes _________ No _________
If **no,** sign and date at the bottom and return this form to HealthComp.
If **yes,** please provide relevant information for each additional Carrier/Plan providing other health insurance coverage for your family below.

#1 Carrier/Plan Name: ______________________ Policyholder name: ______________________ DOB: ________

Plan Type (check one): __ Employer __Medicare Part: A B D __Medicaid __ Individual __ Retiree __Other______
(circle all that apply)

Coverage type: __Medical __ Dental __Vision __RX Effective Date: _________ Termination Date: __________
(check all that apply) (if applicable)

#2 Carrier/Plan Name: ______________________ Policyholder name: ______________________ DOB: ________

Plan Type (check one): __ Employer __Medicare Part: A B D __Medicaid __ Individual __Retiree __Other______
(circle all that apply)

Coverage type: __Medical __ Dental __Vision __RX Effective Date: _________ Termination Date: __________
(check all that apply) (if applicable)

Carrier #'s	**Covered dependents**	**Relationship to policyholder**	**Is coverage court-ordered?**	**Person with whom child primarily resides & their relationship to child**
(see above)			(If yes, attach relevant pages)	
_____	____________________	____________	Yes____ No____	_______________________________
_____	____________________	____________	Yes____ No____	_______________________________
_____	____________________	____________	Yes____ No____	_______________________________
_____	____________________	____________	Yes____ No____	_______________________________
_____	____________________	____________	Yes____ No____	_______________________________

Please list the Name and Date of Birth for all covered dependents who do not have other health insurance:

Dependent name	**DOB**	**Dependent name**	**DOB**
____________________	____________	____________________	____________
____________________	____________	____________________	____________

I declare under penalty of perjury that the above statements are true and complete to the best of my knowledge.

Your Signature: ____ Date: ________________________