COVERAGE INFORMATION FORM (CLAIM FORM)

Participant Name:

A. Social Security and Medicare HICN numbers (if used) are required due to Medicare mandatory reporting rules. Please list the social security number and, if applicable, the Medical HICN (Health Insurance Claim Number) for each of your covered dependents (spouse and children):

Name:	SSN:	_ Medicare HICN:			
Name:	_SSN:	_ Medicare HICN:			
Name:	_SSN:	Medicare HICN:			
Name:	_SSN:	Medicare HICN:			
Name:	_SSN:	_ Medicare HICN:			
(If additional space is needed, plea	ase write on the back of this f	orm.)			
В.					
Married Single Divo					
If married: Spouse's Name:		Social Security #:			
Date of Birth: Days	time Phone:				
Is your spouse or your dependent's Mother/Father Employed? Yes No					
Does your Employer offer insuran	ce coverage? Yes No	Employee Family			
		Phone:			
		State:			
Retired: Yes No Dat					

C. If your spouse or dependent's Mother/Father is not employed and there is no other insurance for any person covered under this plan, go to section E.

If your Spouse or your dependent's Mother/Father carries Medical/Dental coverage through their place of employment, please complete below.

Other Insurance Carrier	r Name:		P	olicy Nun	nber:	
Address:						
Phone:	Nam	e of Policyhol	der:			
		Termination Date:				
Does this plan cover an	y dependents? Yes	No				
Please list all depender please use back of form		• •	•	•	onal space is	needed,
Full Name	DOB	Medical	Dental	RX	Ortho	Vision
	······					
	······					

D. In the case of divorce or legal separation, which parent has custody? Name of Custodial Parent: ______ Which parent claims exemption on their Federal Income Tax Return? Name: _____

E. If Medicare covers you, your spouse or any other family members, please complete below. Name: ______ Date: _____ Part A: __ Part B: __ Age 65: __Disabled: ___ ESRD: ____

Have you elected Medicare Part D Prescription Coverage? Yes __ No__ Effective Date: _____

Please submit a copy of your Medicare card(s)

F. Dependent children covered under Divorce or Court Order:

Include a copy of the court order, QMSCO or Divorce Decree with this form (unless previously submitted).

Which Party has physical custody of the dependent child(ren)? ______ Does the Divorce Degree or Court Order stipulate which party is responsible for maintaining health

coverage on the dependent child(ren)? Yes _____ No _____

If the answer to the above question is 'YES", complete the following (if additional space is needed, use back of form).

Dependent Full Name	Parent Name (address & phone)	Insurance Name	Date

Please sign and date the form and return.

Authorization to release information: The above answers are true and complete according to the best of my knowledge and believe. I hereby authorize any Employer, Insurance Company, Medical prepayment plan, service organization, Physician, Practitioner or other person; any hospital, including Veteran's Administration or other institution to release to or obtain from my Benefits Administrator any medical or payment information that may be required to establish the validity of my claims. I further authorize said company, person, or organization to disclose any personal claim information required for medical case study or review. A photocopy of this authorization shall be considered as effective and valid as the original.

Employee Signature:	Date:
Spouse Signature:	Date: