Section A. Other Insurance

Are you or is any member of your family enrolled in any other health or dental insurance program (including Medicaid)?

O **No – Please go to section B** O **Yes – Please complete the following:**

Please provide the details of the other medical / dental coverage (excluding Medicare). **If other insurance is Medicare, go to Section B**

Name and Date of Birth of Policyholder of the other coverage:

Relationship to Subscriber:

O Self O Spouse O Child O Other

Date of Birth: ___/___/___

Employer Name (if applicable):

Is the Policyholder actively employed?

O Yes O No

Employment Date: ___/___/___

Is this a COBRA or state continuation coverage policy?

O Yes O No

Effective Date: ___/___/___

Health Insurance Company Name, Address, Group Number and Phone Number:	Dental Insurance Company Name, Address, Group Number and Phone Number:
Policy Number:	Policy Number:
Effective Date: ___/___/___ Cancel Date: ___/___/___	Effective Date: ___/___/___ Cancel Date: ___/___/___
Type of Contract: O Single O Family – list covered dependents:	Type of Contract: O Single O Family – list covered dependents:

Type of Coverage ☐ Medical/Surgical ☐ Major Medical ☐ Hospital ☐ Drug ☐ Vision ☐ Dental

If this coverage is provided for dependent child(ren) whose natural parents are divorced, separated, or were never married, it is necessary to attach a copy of the court decree that identifies which parent is responsible for providing health coverage. If the court decree does not specify who is responsible, then it will be necessary to provide a copy of the custody arrangement for the dependent child(ren). If you have previously provided the court decree to us, you do not have to provide it again.

Section B. Medicare-Related Information

Have you or any of your covered dependents been enrolled in Medicare over the past 12 months?

O **No - Please go to section C** O **Yes - Please complete the following:**

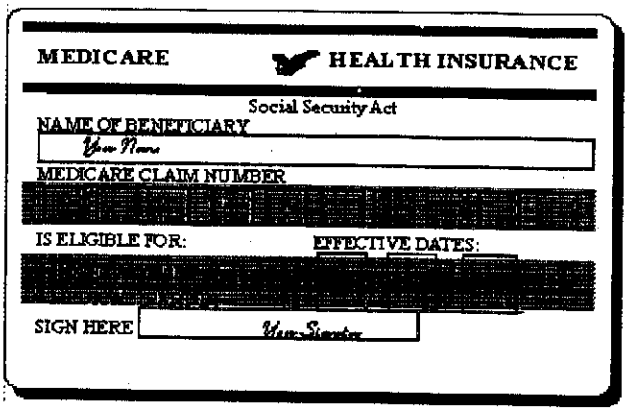
Reason(s) for Medicare coverage - Please check all that apply:

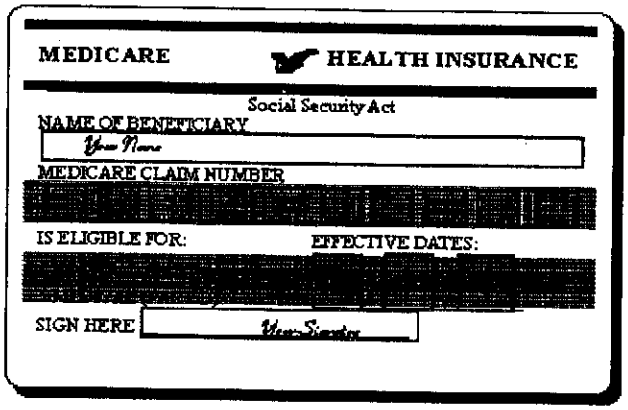
☐ Over 65
☐ Disabled - 1st Date of Disability: ___/___/___
☐ End-Stage Renal Disease - 1st Date of Dialysis: ___/___/___
☐ Transplant Date if Applicable: ___/___/___
☐ Medicare Replacement ☐ Part D

Status of policyholder under this policy: O Actively Employed O Retired - Retirement Date: ___/___/___

Subscriber ID:

For You (Complete the shaded areas) For Your Dependent





Section C. Motor Vehicle Accidents

Have you or any member of you family been involved in a motor vehicle accident in the past 12 months?

O **No - Please go to section D** O **Yes - Complete the following:**

Date of onset of injury or illness: ☐/☐/☐

Name of family member(s) involved in the injury/illness:

Describe the nature of the injury or illness:

Detailed description of how the illness or injury occurred:

Has a motor vehicle accident claim been filed? O No O Yes

Is the member still being treated for this injury or illness? O Yes O No Last date of treatment: ☐/☐/☐

Automobile Carrier Name, Address and Phone #:

Automobile Carrier Claim and/or File #:

Section D. Employment Accidents

Have you, or any member of your family been involved in an injury, illness or disability which was casually related to their employment?

O **No – Complete certification at bottom** O **Yes – Complete the following:**

Date of onset of injury or illness: ☐/☐/☐

Name of family member(s) involved in the injury/illness:

Describe the nature of the injury or illness:

Detailed description of how the illness or injury occurred:

Has a workers' compensation claim been filed? O No O Yes

Is the member still being treated for this injury or illness? O Yes O No - Last day of Treatment: ☐/☐/☐

Workers' Compensation Carrier Name, Address and Phone #:

Workers' Compensation Carrier Claim and/or File #:

Workers' Compensation Board # (if available):

Certification: I hereby certify that the information listed is accurate and is to the best of my knowledge. I authorize the release of any relevant information to my insurance carrier.

Signature: **Date:** **Phone Number:**