



**SECTION A: OTHER INSURANCE COMPANY INFORMATION (Attach additional page(s) if there is more than one other insurance policy.)**

Other Insurance Name, Address, Street, City, Zip				
Type of Coverage: ( ) Single ( ) Employee & Child Only ( ) Children Only ( ) Family ( ) Employee & Spouse ( ) Spouse Only				
Name of Policy Holder		Date of Birth	Policyholder's Gender: ( ) Male ( ) Female	
Other Insurance Policy #	Group No.	Other Insurance Phone #		Policy Effective Date ____/____/____
Employees in Group: ( ) Less than 20 ( ) 20 or more ( ) 100 or more ( ) Unknown				
Persons Covered by Other Insurance	Date of Birth	Relationship		Social Security No.
1.				
2.				
3.				
4.				

**SECTION B: COMPLETE THIS SECTION IF YOU HAVE DEPENDENT CHILDREN AFFECTED BY A DIVORCE, LEGAL SEPARATION, COURT DECREED CUSTODY/GUARDIANSHIP, OR CHILD SUPPORT ORDER.**

Does a court decree state who has financial responsibility for providing health coverage for any dependent?

( ) NO ( ) YES, the court decree specifies that \_\_\_\_\_ has responsibility.

Child's Name	Custodial Parent(s) Name and Month/Day of Birth	Non Custodial Parent(s) Name and Month/Day of Birth	Joint Custody Yes/No	Person with whom child lives

Provide a copy of the insurance card for each policy that covers the dependents listed above.

**SECTION C: MEDICARE COVERAGE**

Subscriber's Name	Sex	Medicare HIC Number	Effective Date	Term Date
	( ) Male ( ) Female		Part A _____ Part B _____	_____
Location of Treatment: ( ) In Home ( ) Dialysis Facility		Date of First Dialysis Treatment:	Reason(s) for Medicare: ( ) Age ( ) Disability ( ) End Stage Renal Disability	

Spouse or Dependent	Sex	Medicare HIC Number	Effective Date	Term Date
	( ) Male ( ) Female		Part A _____ Part B _____	_____
Location of Treatment: ( ) In Home ( ) Dialysis Facility		Date of First Dialysis Treatment:	Reason(s) for Medicare: ( ) Age ( ) Disability ( ) End Stage Renal Disability	

**SECTION D: This section must be completed and signed by the subscriber.**

To the best of my knowledge the information provided is true, accurate, and complete. Unanswered questions indicate they do not apply. My signature authorizes any Medicare carrier, intermediary, or any other insurance carrier or plan to make available to Corporate Plan Management all information concerning claims filed by me or on my behalf.

Subscriber's Signature	Date of Birth	Work Phone No.	Home Phone No.	Today's Date