## SUBSCRIBER INFORMATION (Please Print Clearly or Type)

Subscriber Name: _____

ID Number: _____

## COVERAGE INFORMATION

**Please note: if you, your spouse or dependent(s) have:**

- Other coverage, please complete section 1, then sign and date the form.
- No other coverage, please complete section 2, then sign and date the form.

**1. Other Coverage (list each separately)**

Carrier Name: _____
Carrier Address: _____
Subscriber's Name: _____ Policy #_____Subscriber's SS# _____
Policy Effective Dates: Start_____ End _____ Covered Dependents _____
**Coverage type:**
(Check applicable) Hospital____ Major Medical____Prescription ____Dental____ Retiree_____ Cobra_____ Other____

**2. No Other Coverage**

If your spouse does not have other health coverage, please indicate the reason:

Benefits not offered_____ Unemployed_____ Self-employed_____ Waived, as of: _____

Part-time employee (not eligible for benefits) _____

Other, please explain: _____

## SUBSCIBER SIGNATURE

**I certify that the above information is correct and understand that I am obligated to provide this information accordance with the Plan Document. Failure to provide complete and accurate information may result in a delay in the processing of claims.**

Print Your Name: _____ ID #: _____

Signature: _____ Date: _____