



Hello,

To help us properly handle future claims, please tell us about any other healthcare coverage you and/or your dependents may have. Examples include another group plan, an individual policy, COBRA, Medicare, state programs (such as Medicaid, CHIP, etc.), Social Security benefits due to a disability, or medical expenses covered by another person due to a court order/decreed.

Please complete this form and submit it by:

- Mailing it to the address above;
- Faxing it to: 1.716.541.6672; or,
- Taking a picture of it, and emailing it to: [forms.direct@meritain.com](mailto:forms.direct@meritain.com).

OTHER INSURANCE COVERAGE		
Group Name	Employee Name	Employee date of birth
Group number (if you already have an ID Card from Meritain Health)	Member ID (if you already have an ID Card from Meritain Health)	
<p><b>Do you and/or any of your dependents have any <u>other</u> health coverage?</b></p> <p><input type="checkbox"/> YES Please <u>complete the appropriate section(s) on the other side of this form</u> and return.</p> <p><input type="checkbox"/> NO Please return.</p>		

**IF THERE IS OTHER HEALTHCARE COVERAGE,**  
PLEASE COMPLETE THE APPROPRIATE SECTION(S) ON THE OTHER SIDE OF THIS FORM.

*Failure to return this form may result in non-payment of claims.*

For each type of other insurance coverage you and/or your dependents have, please complete the appropriate section.

For coverage through: <b>ANOTHER GROUP PLAN, AN INDIVIDUAL POLICY, COBRA OR STATE PROGRAM</b> (ex: Medicaid)		
What type of coverage is this? <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Name of insurance company / program		Name of policy holder
Birthdate of policy holder	Effective date of coverage	Termination date of coverage (if applicable)
Please list <b>all</b> family members covered by this plan, and their relation to the policy holder		

For coverage through: <b>ANOTHER GROUP PLAN, AN INDIVIDUAL POLICY, COBRA OR STATE PROGRAM</b> (ex: Medicaid)		
What type of coverage is this? <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision		
Name of insurance company / program		Name of policy holder
Birthdate of policy holder	Effective date of coverage	Termination date of coverage (if applicable)
Please list <b>all</b> family members covered by this plan, and their relation to the policy holder		

For coverage through: <b>MEDICARE</b>		
Name of person covered by Medicare		Medicare ID number:
Your retirement date (if applicable)		Your spouse's retirement date (if applicable)
Part A effective date(s)	Part B effective date(s)	Part D effective date(s)
Reason for Medicare: <input type="checkbox"/> Over age 65 <input type="checkbox"/> Total disability <input type="checkbox"/> End-stage renal disease (provide dialysis date) _____		

<b>COURT ORDER OR DECREE</b>	
Covered Individuals	Effective date
Name of person responsible for medical expenses	Address of person responsible for medical expenses
<b>Please include a copy of the legal documentation showing responsibility for medical expenses.</b>	