Employee :
Employee ID# :
Patient Name :
Claim:

Dear Member:

We need to update your file information. Please complete the questions below regarding other insurance coverage that you or your dependents may have.

1. Name and address of other insurance company:_____

_____

_____Phone:_____

_____ _____ _____ _____

Effective Date Group Number Policy Number Term Date

**********PLEASE SUBMIT A COPY OF FRONT AND BACK OF ID CARD******

2. Name of Policy Holder of Other Group Policy:

_____

Policy Holder's Social Security Number:_____

3. Name of employer:_____

Address:_____Phone:_____

4. Please list names of dependents who are covered under this other group coverage:

_____ _____ _____

_____ _____ _____

I certify that the above information is true:_____ Date: _____

Subscriber's Signature

Thank you for your cooperation.

Sincerely,

Claims Department