OTHER INSURANCE INQUIRY

THIS INFORMATION IS REQUIRED TO UPDATE
OUR RECORDS ON AN ANNUAL BASIS

Please be sure to complete all areas that apply. If not applicable enter NA, sign and date the bottom of this form. You must also complete the back of this form. If you do not have Medicare or Medicaid coverage, please enter NA, sign and date the bottom of the form.

1. Do you, your spouse or your dependents have any Group Medical, Dental or Vision coverage through an Employer other than your coverage with Coventry Health Care?

   _______ No (if no, please sign form below)   ______ Yes (if yes, please proceed to question 2)

2. Please provide the name, address and phone number of the other Employer Group Medical, Dental or Vision coverage:

   Medical:____

   Dental: ____

   Vision: ____

3. Please complete the following information concerning the above coverage. Include all of the members covered under the above policy and their dates of birth: (if additional space is needed, please attach a separate piece of paper.)

4. Policyholder/Employee's Name:_______________________________ DOB: ____________
   Spouse's Name: _______________________________________ DOB: ____________
   Dependent's Name: ____________________________________ DOB: ____________
   Dependent's Name: ____________________________________ DOB: ____________
   Dependent's Name: ____________________________________ DOB: ____________
   Insurance Policy Number: ____
   Effective Date: ____
   Termination Date (if policy is terminated): _______________________________
   Employer's Name: ____

   Status of Employment: (circle one)   Active   Retired   Disabled

I/We certify that the above information is true and correct, and authorize any union, trust fund, employer, insurance carrier, physician or hospital to furnish information to Coventry Health Care about any other benefits to which I/We may be entitled.

_______________________________________   ____________________

Insured's Signature   Date

____

(SEE BACK OF THIS FORM)

Print Name

MEDICARE OR MEDICAID INSURANCE INQUIRY

THIS INFORMATION IS REQUIRED TO UPDATE OUR RECORDS ON AN ANNUAL BASIS

Do you, your spouse or your dependents have medical coverage with Medicaid or Medicare?

______ No (if no, please sign and date the bottom of the form)

______ Yes, I have Medicare

Medicare Number: ____________________________

Medicare Part A Effective Date: ________________

Medicare Part B Effective Date: ________________

Medicare Part C (Advantage Plans)
Effective Date: ______________________________

Medicare Part D Effective Date: ________________

______ Yes, my spouse and/or dependent(s) have Medicare

Member Name: ______________________________

Medicare Number: ____________________________

Medicare Part A Effective Date: ________________

Medicare Part B Effective Date: ________________

Medicare Part C (Advantage Plans)
Effective Date: ______________________________

Medicare Part D Effective Date: ________________

If under the age of 65 and on Medicare please include reason for Medicare coverage:

____

____

____Yes, I and/or my dependent(s) have Medicaid

Medicaid Number: ____

List person(s) covered: ____

___ ____

I/We certify that the above information is true and correct, and authorize any union, trust fund, employer, insurance carrier, physician or hospital to furnish information to Coventry Health Care about any other benefits to which I/We may be entitled.

______________________________________ ____________________

Insured's Signature Date

____

Print Name