Community Health Direct
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OTHER HEALTH INSURANCE COVERAGE FORM
COORDINATION OF BENEFITS

We are in the process of updating our membership files. Please complete this form in its entirety and return in the enclosed envelope. This information is necessary for timely processing of claims and coordination of benefits. Thank you in advance for your cooperation.

Employee Name: _____

Spouse Name/Domestic Partner: _____

Employee Social Security No: _____ Health Plan ID No: _____

Employee Contact Phone No: _____

Employee Home Address: _____

Employee: ☐ Actively employed ☐ Retired Retirement Date: _____ ☐ Disabled

Spouse/Domestic Partner: ☐ Actively employed ☐ Retired Retirement Date: _____ ☐ Disabled

Do you (employee) have other medical insurance? ☐ Yes ☐ No **If yes, complete section A**

Does your spouse/domestic partner have other medical insurance? ☐ Yes ☐ No **If yes, complete section B**

Do your dependents have other medical insurance? ☐ Yes ☐ No **If yes, complete section B**

SECTION A (Other Insurance for employee)

Policyholder's Name: _____ Date of Birth _____

Social Security No: _____ Health Plan ID No: _____

Name of Insurance Carrier: _____ Contact Phone No: _____

Insurance Carrier Address: _____

Effective Date: _____ Termination Date: _____

If Medicare applies: ☐Part A Effective Date: _____ ☐Part B Effective Date: _____

Family members covered by other insurance: _____

_____

SECTION B (Other Insurance for spouse/domestic partner or dependents)

Policyholder's Name: _____ Date of Birth _____

Social Security No: _____ Health Plan ID No: _____

Name of Insurance Carrier: _____ Contact Phone No: _____

Insurance Carrier Address: _____

Effective Date: _____ Termination Date: _____

If Medicare applies: ☐Part A Effective Date: _____ ☐Part B Effective Date: _____

Family members covered by other insurance: _____

_____

Who has primary responsibility for health coverage? (If policyholder is not your spouse/domestic partner, **please enclose a copy of the applicable portion of the divorce decree, court order or support order):** _____

_____

Signature: _____ Date: _____