MUNICIPAL HEALTH BENEFIT PROGRAM
MULTIPLE COVERAGE INQUIRY

This completed form is Mandatory at time of enrollment of a new Employee & Mandatory on a yearly basis.

In order to pay your claims quickly and accurately, we need complete information on any other insurance that you or your dependents (covered by MHBP) may have. **Please complete this form and return it as soon as possible.**

MHBP Member/Employee Name	Member/Employee SSN or ID#	Name of Employer/Group	
Current Mailing Address	City	State	Zip Code

1. PLEASE ANSWER THIS QUESTION

Do you or any family member covered as your dependent by MHBP, have any other medical, dental or vision insurance coverage?

Yes ☐ If Yes, please complete sections 2, 3 and 4 (space has been provided on the back of this form for persons with more than one health care plan).

No ☐ If No, please sign and date the bottom of this form (Section 4) and return this form to us as soon as possible.

2.OTHER INSURANCE INFORMATION (More space provided on the back of this form)

COMPLETE IN FULL (If Other Insurance is Medicare, Please go to Section 3 of this form)

Name of Insurance Company		Insurance Company Phone Number ( )	
Insurance Company Address (Street or PO Box, City, State and Zip Code)		Employer that provides this coverage	
Name of Policy Holder	Policy Holder Identification No.	Effective Date	Termination Date *

Type of Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Drug Card Services

Type of Policy ☐ Single ☐ Family ☐ Medicaid ☐ Retiree Coverage

Persons Covered by Other Insurance

Name	Social Security Number	Date of Birth	Relationship to Policy

3. Medicare Information (PLEASE PROVIDE COPY OF MEDICARE CARD)

Name of Medicare Policy Holder		Medicare Identification Number
Effective Date of Part A	Effective Date of Part B	Effective Date of Part D

Reason for Medicare Eligibility: ☐ **Age 65 or Older** ☐ **Disability *** ☐ **Renal Disease**

*** If you are eligible for Medicare due to a Disability please attach a copy of Social Security Disability Approval Letter.**

Name of Spouse or other Dependent who has Medicare		Medicare Identification Number
Effective Date of Part A	Effective Date of Part B	Effective Date of Part D

Reason for Medicare Eligibility: ☐ **Age 65 or Older** ☐ **Disability *** ☐ **Renal Disease**

*** If you are eligible for Medicare due to a Disability please attach a copy of Social Security Disability Approval Letter.**

NOTE: ALL CLAIMS ON YOU & YOUR COVERED DEPENDENTS WILL BE HELD UNTIL THIS INFORMATION IS RECEIVED. FAILURE TO RESPOND TO MAY RESULT IN CLAIMS BEGIN DELAYED OR DENIED.

MHBP Use Only

4.IF YOU ARE DIVORCED AND/OR COVERING CHILDREN FROM A PREVIOUS RELATIONSHIP OR COVERING STEPCHILDREN

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No **A copy of court order must accompany this form.**

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No **A copy of court order must accompany this form.**

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No **A copy of court order must accompany this form.**

OTHER INSURANCE INFORMATION

(If Other Insurance is Medicare, Please go to the Medicare Information section of this form.)

Name of Insurance Company	Insurance Company Phone Number ( )
Insurance Company Address (Street or PO Box, City, State and Zip Code)	Employer that provides this coverage

Name of Policy Holder	Policy Holder Identification No.	Effective Date	Termination Date *

*** If the other coverage has terminated please attach a copy of the termination letter**

Type of Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Drug Card Services
Type of Policy ☐ Single ☐ Family ☐ Medicaid ☐ Retiree Coverage

Persons Covered by Other Insurance

Name	Social Security Number	Date of Birth	Relationship to Policy Holder

NOTE: ANYTIME ANY OF THIS INFORMATION CHANGES MHBP MUST BE NOTIFIED WITH AN UPDATED FORM AND A CERTIFICATE OF COVERAGE SHOWING THAT THIS OTHER INSURANCE TERMED .

Signature of Member/Employee Date

(rev04/14)