Employee/Policyholder Name:

Employer:

Patient name:

Relationship:

Has the patient been enrolled in any other health care program within the past year other than the current health program they are enrolled in today?
(Such as: Medicare, Medicaid, Other Employer's Insurance, Individual Marketplace Coverage.)

( ) If No, please sign, date, and return ( ) If Yes, complete the following and return.

Start Date of Prior Benefit Coverage: _____
Termination Date of Prior Benefit Coverage (if applicable): _____
If a dependent, ages 19-26, employed: ( ) Full-time ( ) Part-time
Prior Employer/Benefit Program Name: _____
Prior Employer/Benefit Program Phone Number:_____
Prior Benefit Policy/Plan Number: _____
Primary Policyholder/Insured Name: _____
Primary Policyholder/Insured Date of Birth: _____
Prior Coverage: ( ) IND ( ) EE/Spouse ( ) EE/Child(ren) ( ) Family
Prior Benefits: ( ) Medical ( ) Dental ( ) Vision

Signature: _____

Date: _____

Phone Number: _____

Return your form to us by mail, fax, or web portal.
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Fax: 302-629-8416