Information is needed regarding any possible other coverage, including Medicare, for all covered persons under this policy. This information is required for accurate benefit determination and timely processing of claims in accordance with the Plan's Coordination of Benefits Provision. Failure to respond may result in claim delay or denial.

Employee Name:

Phone number: Date of Birth:

Address:

Employer Group Name or Number:

Check here if no other coverage exists for you & your covered family members and please sign & date below.

If other coverage exists for you or any covered family member, list each family member below and provide the requested other coverage information.

Type of Other Coverage (Medical/Dental/Medicare):

Policy Holder : Date of birth

Persons Covered Under Other Insurance:

Other Insurance Company Name:

Effective Date:

Policy Number:

Additional Comments:

I certify that the information provided is accurate to the best of my knowledge. I understand and agree that any false information, misrepresentation or omission of facts may result in further action by the Health Care Plan. At any time if there is a change in other coverage, you are required to notify the Plan.

Signature: Date:

Your cooperation in this matter is appreciated.

Please notify IMS as stated above or contact Customer Service at 1-800-426-8739 x5050 with any questions.