

# MUNICIPAL HEALTH BENEFIT FUND MULTIPLE COVERAGE INQUIRY

**This completed form must accompany all New Enrollment Applications at the time of enrollment of a new Member/Employee**

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

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

### 1. PLEASE ANSWER THIS QUESTION

Are/were you, or any family member covered as your dependent by MHBF, have any other dental, medical, or vision insurance coverage? Include any coverage by MHBF, any other company or Medicare.

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) ( 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 <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Drug Card Services			
Type of Policy <input type="checkbox"/> Single <input type="checkbox"/> Family <input type="checkbox"/> Medicaid <input type="checkbox"/> Retiree Coverage			

### Persons Covered by Other Insurance

Name	Social Security Number	Date of Birth	Relationship to Policy Holder

### 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: <input type="checkbox"/> Age 65 or Older <input type="checkbox"/> Disability * <input type="checkbox"/> Renal Disease			
<b>* If you are eligible for Medicare due to a Disability please attach a copy of Social Security Disability Approval Letter.</b>			
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: <input type="checkbox"/> Age 65 or Older <input type="checkbox"/> Disability * <input type="checkbox"/> Renal Disease			

**WAIVER OF PRE-EXISTING CONDITIONS WILL APPLY IF YOU HAVE OR HAD CONTINUAL COVERAGE PRIOR TO YOUR MHBF EFFECTIVE DATE. THE CERTIFICATE OF COVERAGE FROM YOUR FORMER INSURANCE CARRIER IS REQUIRED FOR WAIVER OF PRE-EXISTING CONDITIONS FOR TERMINATED POLICIES.**

MHBF Use Only

**PLEASE SEE THE REVERSE SIDE OF THIS FORM FOR ADDITIONAL REQUIRED INFORMATION.**

**4. Please complete this section only if you are divorced and/or are covering children from a previous relationship**

**or covering step-children.**

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee
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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
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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
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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 (      )
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Insurance Company Address (Street or PO Box, City, State and Zip Code)	Employer that provides this coverage
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Name of Policy Holder	Policy Holder Identification No.	Effective Date	Termination Date *
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**\* 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: ALL CLAIMS ON YOU AND YOUR COVERED DEPENDENTS WILL BE HELD UNTIL THIS INFORMATION IS RECEIVED. FAILURE TO RESPOND TO THIS INQUIRY MAY RESULT IN CLAIMS BEING DELAYED OR DENIED.**

Signature of Member/Employee	Date	(rev09/09)
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