

Member ID:

Please check one (1) of the following:

- NO, the members on this coverage do not have any other insurance.
- YES, the members on my plan have other insurance. Current information is below.

What type of coverage does your other health insurance provide? (*Check all that apply*):

- Medical Dental
- Vision Prescription Drug (Rx)

Insurer name:	
Address:	
Phone:	
Group number:	
Policyholder name and date of birth:	
Policy effective (start) date:	
Policy term (end) date: (leave blank if still active)	

Please list all family members covered by this OTHER insurance policy and their ID numbers for that policy. If you are not the policyholder, include yourself.

<u>Name</u>	<u>Member ID Number</u>

Please email completed form to phservice@peakhealth.org