Other Insurance Coverage Information

Meritain Health®
an aetna company

Complete and return to:
Meritain Health
P.O. Box 853921
Richardson, TX 75085-3921
Fax: 1.763.852.5057

Hello,

To help us properly handle future claims, please tell us about any other health care coverage you and/or your dependents may have. Examples include another group plan, an individual policy, COBRA, Medicare, state programs (such as Medicaid, CHIP, etc.), Social Security benefits due to a disability, or medical expenses covered by another person due to a court order/decree.

You can provide this information online by:

- Logging in to **www.meritain.com**.
- Going to Benefits and Coverage in the menu bar.
- Clicking on *Coordination of Benefits*.

Or, you can complete this printed form and submit it by:

- Mailing it to the address above.
- Faxing it to: **1.716.541.6672**.
- Taking a picture of it and emailing it to **forms.direct@meritain.com**.

OTHER INSURANCE COVERAGE		
Group Name	Employee Name	Employee date of birth
Group number *(if you already have an ID card from Meritain Health®)*	Member ID *(if you already have an ID card from Meritain Health)*	
Do you and/or any of your dependents have any other health coverage? ❑ YES Please *complete the appropriate section(s) on the other side of this form* and return. ❑ NO Please return.		

IF THERE IS OTHER HEALTH CARE COVERAGE,
PLEASE COMPLETE THE APPROPRIATE SECTION(S) ON THE OTHER SIDE OF THIS FORM.

Failure to return this form may result in non-payment of claims.

For each type of other insurance coverage, you and/or your dependents have, please complete the appropriate section.

For coverage through: **ANOTHER GROUP PLAN, AN INDIVIDUAL POLICY, COBRA OR STATE PROGRAM** *(ex: Medicaid)*		
What type of coverage is this? ❑ Medical ❑ Dental ❑ Vision		
Name of insurance company / program	Name of policy holder	
Birthdate of policy holder	Effective date of coverage	Termination date of coverage *(if applicable)*
Please list **all** family members covered by this plan, and their relation to the policy holder.		

For coverage through: **ANOTHER GROUP PLAN, AN INDIVIDUAL POLICY, COBRA OR STATE PROGRAM** *(ex: Medicaid)*		
What type of coverage is this? ❑ Medical ❑ Dental ❑ Vision		
Name of insurance company / program	Name of policy holder	
Birthdate of policy holder	Effective date of coverage	Termination date of coverage *(if applicable)*
Please list **all** family members covered by this plan, and their relation to the policy holder.		

For coverage through: **MEDICARE**		
Name of person covered by Medicare	Medicare ID number:	
Your retirement date *(if applicable)*	Your spouse's retirement date *(if applicable)*	
Part A effective date(s)	Part B effective date(s)	Part D effective date(s)
Reason for Medicare: ❑ Over age 65 ❑ Total disability ❑ End-stage renal disease *(provide dialysis date)* _____		

COURT ORDER OR DECREE	
Covered Individuals	Effective date
Name of person responsible for medical expenses	Address of person responsible for medical expenses
Please include a copy of the legal documentation showing responsibility for medical expenses.	

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