HealthComp

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Other Insurance Information Questionnaire

You can also complete this form on HCOnline at: https://hconline.healthcomp.com/forms-oi

In order to fully document our system regarding other health insurance, it is important that you complete the following:

Member Name_____ Member ID # _____ **Group No.** L35

Do you or any of your covered dependents have other existing health coverage (not including Medicare)?

If YES, please provide relevant information for each additional Carrier/Plan providing other health insurance coverage for you & your family below. If NO, please disregard.

#1: Carrier/Plan Name: _____ Policyholder name: _____ DOB: _____

Plan Type (*check one*): ❑ Employer ❑ Medicaid ❑ Individual ❑ Retiree ❑ Other _____

Coverage type: ❑ Medical ❑ Dental ❑ Vision ❑ Rx (*check all that apply*) Effective date: _____ Termination Date: _____ *(if applicable)*

#2: Carrier/Plan Name: _____ Policyholder name: _____ DOB: _____

Plan Type (*check one*): ❑ Employer ❑ Medicaid ❑ Individual ❑ Retiree ❑ Other _____

Coverage type: ❑ Medical ❑ Dental ❑ Vision ❑ Rx (*check all that apply*) Effective date: _____ Termination Date: _____ *(if applicable)*

USING THE ABOVE CARRIER NUMBERS, PLEASE FILL OUT THE FOLLOWING INFORMATION FOR EACH COVERED DEPENDENT

Carrier # (see above)	Covered dependents	Relationship to policyholder	Is coverage court-ordered? (if yes, attach relevant pages)	Person with whom child primarily resides & their relationship to child (If applicable)
_____	_____	_____	Yes _____ No _____	_____
_____	_____	_____	Yes _____ No _____	_____
_____	_____	_____	Yes _____ No _____	_____
_____	_____	_____	Yes _____ No _____	_____
_____	_____	_____	Yes _____ No _____	_____

I declare under penalty of perjury that the above statements are true and complete to the best of my knowledge.

Your Signature:_____ Date: _____