group health Cooperative of eau claire™

Additional Insurances Form

Please fill out the information below if you receive additional health insurance benefits from other health insurance companies.

Dear Member,

We are required to request information from members regarding other health insurance coverage. This is to comply with Wisconsin State Law governing coordination of insurance benefits. Other health insurance includes Medicare or health insurance coverage through another carrier held by your or any of your dependents.

It is important to return this completed form as soon as possible to ensure prompt payment of your claims.

If you do not carry any other health insurance, please sign and date the form and write **None** across the box.

Please list all other health insurance coverage held by you or one of your dependents in the boxes below. Refer to the back of this letter for additional spaces.

Insurance Company Information	Dependent Information
Other Insurance Company:_____ Insurance Company Phone:_____ Address:_____ City:_____ State:___ Zip:_____ Policy Number:_____ Group Number:_____ Circle One: ○Family ○Single Circle One: ○Medical ○Dental ○HIRSP ○Vision Prescription Coverage: ☐Yes ☐No Effective Date:_____ End date:_____ Name of Policy Holder:_____ Date of Birth:_____	Name:_____ Social Security #:_____ Birth Date: _____ Street Address: _____ City:_____ State:___ Zip:_____ Name:_____ Social Security #:_____ Birth Date: _____ Street Address: _____ City:_____ State:___ Zip:_____ Name:_____ Social Security #:_____ Birth Date: _____ Street Address: _____ City:_____ State:___ Zip:_____

Medicare Information	Medicare Information
Name:_____ DOB:_____ Medicare Card Number:_____ Part A Effective Date:_____ Part B Effective Date:_____ Part D Efective Date:_____	Name:_____ DOB:_____ Medicare Card Number:_____ Part A Effective Date:_____ Part B Effective Date:_____ Part D Efective Date:_____

I certify that the insurance information provided above is accurate to the best of my knowledge.

Signature:_____ Date:_____

Your Phone Number:_____ Employer:_____

Insurance Company Information	Dependent Information
Other Insurance Company:____________ Insurance Company Phone:____________ Address:____________ City:____________ State:____ Zip:________ Policy Number:____________ Group Number:____________ Circle One: ○Family ○Single Circle One: ○Medical ○Dental ○HIRSP ○Vision Prescription Coverage: ☐Yes ☐No Effective Date:____________ End date:____________ Name of Policy Holder:____________ Date of Birth:____________	Name:____________ Social Security #:____________ Birth Date:____________ Street Address:____________ City:____________ State:____ Zip:________ Name:____________ Social Security #:____________ Birth Date:____________ Street Address:____________ City:____________ State:____ Zip:________ Name:____________ Social Security #:____________ Birth Date:____________ Street Address:____________ City:____________ State:____ Zip:________

Insurance Company Information	Dependent Information
Other Insurance Company:____________ Insurance Company Phone:____________ Address:____________ City:____________ State:____ Zip:________ Policy Number:____________ Group Number:____________ Circle One: ○Family ○Single Circle One: ○Medical ○Dental ○HIRSP ○Vision Prescription Coverage: ☐Yes ☐No Effective Date:____________ End date:____________ Name of Policy Holder:____________ Date of Birth:____________	Name:____________ Social Security #:____________ Birth Date:____________ Street Address:____________ City:____________ State:____ Zip:________ Name:____________ Social Security #:____________ Birth Date:____________ Street Address:____________ City:____________ State:____ Zip:________ Name:____________ Social Security #:____________ Birth Date:____________ Street Address:____________ City:____________ State:____ Zip:________

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Other Insurance Company:____________ Insurance Company Phone:____________ Address:____________ City:____________ State:____ Zip:________ Policy Number:____________ Group Number:____________ Circle One: ○Family ○Single Circle One: ○Medical ○Dental ○HIRSP ○Vision Prescription Coverage: ☐Yes ☐No Effective Date:____________ End date:____________ Name of Policy Holder:____________ Date of Birth:____________	Name:____________ Social Security #:____________ Birth Date:____________ Street Address:____________ City:____________ State:____ Zip:________ Name:____________ Social Security #:____________ Birth Date:____________ Street Address:____________ City:____________ State:____ Zip:________ Name:____________ Social Security #:____________ Birth Date:____________ Street Address:____________ City:____________ State:____ Zip:________

A self-addressed envelope is enclosed for your convenience. If you have questions or need assistance with this form please contact our Member Services department at (715) 552-4300 or (888) 203-7770.

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