Group Plan Solutions
Benefit Administration
A Division of Pekin Insurance®

OTHER INSURANCE VERIFICATION FORM

Participant Information:

Last Name _____ First Name _____ Initial _____

Date of birth _____ Social Security Number _____

Mailing Address _____

City _____ State _____ Zip_____

Is Member covered by any other insurance? _____ Yes _____ No

If so, please complete the information below

Name of insurance company _____ Phone number _____

Policy Number _____ Group Number _____ ID Number _____

Type of plan: Medical _____ Prescription _____ Dental _____ Vision _____

Is this coverage through an employer? _____ Yes _____ No

If yes, list employer _____

Dependent Information:

	Name (first and last)	Relationship to Policyholder	Date of Birth	Covered by other insurance?	Name of Carrier
1.					
2.					
3.					
4.					
5.					

If single, divorced, separated, or remarried with children

(Complete this section even if it duplicates information reported above)

Individual responsible for children's coverage _____

Name _____ Relationship to child _____

Mailing Address _____

City _____ State _____ Zip_____

Date of birth _____ Social Security Number _____

Name of Health Insurance providing child's coverage _____

Policy Number _____ Group Number _____ ID Number _____

Effective date of coverage _____ Type of plan: Medical _____ Prescription _____ Dental _____ Vision _____

	Children's names (first and last)		Who has custody?
1.			
2.			
3.			
4.			

OTHER INSURANCE VERIFICATION FORM
Continued

Medicare Coverage

List family members covered by Medicare:

	Name (first and last)		Medicare number
1.	_____	_____	_____
2.	_____	_____	_____

Check the type of Medicare coverage and the effective date (indicated on the Medicare card)

____ Medicare (Basis of age) Effective Date: _____

____ Medicare Disability (Basis of Disability) Effective Date: _____

____ ESRD Entitlement (Permanent Kidney Failure) Effective Date: _____

Member Name:_____

I have answered all questions truthfully and to the best of my knowledge.

Signature of Member: _____

Date:_____

Please provide a copy of the other medical, prescription, dental, vision, or Medicare card.