Date: _____

RE:

Employer:

Employee:

Claimant:

Last 4 digits of Employee's SSN:

Other Coverage Information Form

In order to update our reinsurance information files and to expedite the reimbursement process, please complete the form below and return it to me along with the attached work status form.

You may fax it to:_____ or you may email it to:_____

Date From: _____ Date Through: _____

- Has the employee or members of his/her family been covered under another group's insurance plan during the time period indicated above: ☐ Yes ☐ No (If no, please skip this section)
- If yes, please complete the information below and state the dates the employee was covered:

  Name and Date of Birth of Insured: _____ Dates Covered: _____

  Name of Insurance Carrier: _____

  Address of Insurance Carrier: _____

  Insurance Policy Number: _____

  Type of Plan: ☐ Medical ☐ Dental ☐ Both

  Type of Coverage: ☐ Family ☐ Individual only
- Does this plan coordinate by Gender or Birthday rule? _____
- If there is family coverage, please list family members covered under the plan:

  _____
- Is the employee or members of his/her family covered under Medicare? ☐ Yes ☐ No

  If no, skip this section and sign at the bottom.
- If yes, please check which Part's, list the effective date and provide a copy of the cards.

  Part A ☐ Part B ☐ Effective Date_____

Signature: _____ Date: _____

**********FORM MUST BE SIGNED BY EMPLOYEE**********

www.paragonbenefits.com

ParagOn

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