Other Coverage Form

The information below is correct to the best of my knowledge. I hereby authorize any other carrier to provide to Aetna information relating to my coverage provided by that carrier in relation to myself and/or other family members.

_______________________________________ ____________________
Aetna Subscriber Signature (or Parent/Guardian Signature) Date

Section A. Subscriber Information – *To be completed by subscriber.*

Name (First, Middle Initial, Last	Social Security Number
Street Address, City, State, Zip Code	
Employer's Group Name ☐	Employer's Telephone Number
Type of Plan ☐ HMO ☐ Open Choice ☐ Managed Choice ☐ Other_______________	Policy/Group Number
Aetna Subscriber ID Number ***(as shown on your ID card)***	Are you employed by another employer/company? ☐ No ☐ Yes If "Yes" and you have coverage under another health plan, please complete **Section D, or E for Medicare.**
Employment Status ☐ Employed ☐ Retired Date of Retirement: __________ ☐ Receiving COBRA Benefits ☐ Long – Term Disability ☐ Other:____	

Section B. Spouse/Domestic Partner Information – *To be completed by subscriber.*

Name (First, Middle Initial, Last	Social Security Number
Employer's Name	
Employer's Address/Telephone Number	Does your Spouse/Domestic Partner have other coverage? ☐ No ☐ Yes If "Yes," complete **Section D, or E for Medicare**
Employment Status ☐ Employed ☐ Retired Date of Retirement: __________ ☐ Receiving COBRA Benefits ☐ Long – Term Disability ☐ Other: ____	

Please Retain a Copy For Your Records.

Section C. Dependent Information – *Complete each box for each dependent covered under your Aetna plan.*

Name (First, Middle Initial, Last)	Date of Birth **(MM/DD/YYYY)**	Relationship To The Subscriber Above **C=Child; S=Stepchild; O=Other (specify)**	Address/Telephone (if different from the subscriber above)	Covered Under Another Group Coverage **Y=Yes; N=No**
1.				
2.				
3.				
4.				
5.				
6.				

If "Yes" is noted for **Covered Under Another Group Coverage** column on any of the dependent child(ren/stepchild(ren) listed above, complete **Section D** and the following:

- Who are the legal parents of the child(ren)? ____________________
- Date of Birth For Each Parent (MM/DD/YYYY) **Father:________________ Mother:________________**

If parents are separated or divorced, complete the following:

- Is there a court order establishing which parent is financially responsible for the dependent child(ren)'s medical, dental, or other health care expenses? ☐ Yes ☐ No If "Yes," specify who____________________
- Who has custody of the dependent child(ren)?____________________
- Who do the child(ren) reside with?____________________
- How many months of the year?____________________

Section D. Other Insurance Carrier/Company Information – *Complete this section if you or your dependents are covered under another group insurance plan.*

Name of other Insurance Carrier (1)		Name of Subscriber of this Policy	ID Number (*as shown on your ID Card)*	Effective Date (MM/DD/YYYY)
Employer Name/Telephone Number	Type of Coverage ☐ Family ☐ Individual	Type of Benefit Provided (check all that apply) ☐ Medical ☐ Dental ☐ Vision ☐ Student ☐ Pharmacy		
		Who is Covered under this group coverage (*Enter individual's name):* 1. ______ 2. ______ 3. ______ 4. ______ 5. ______ 6. ______		
Length of Employment Yrs. ________ Mos. ________				

Name of other Insurance Carrier (2)		Name of Subscriber of this Policy	ID Number (*as shown on your ID Card)*	Effective Date (MM/DD/YYYY)
Employer Name/Telephone Number	Type of Coverage ☐ Family ☐ Individual	Type of Benefit Provided (check all that apply) ☐Medical ☐ Dental ☐ Vision ☐ Student ☐ Pharmacy		
		Who is Covered under this group coverage (*Enter individual's name):* 1. ______ 2. ______ 3. ______ 4. ______ 5. ______ 6. ______		
Length of Employment Yrs. ________ Mos. ________				

Please Retain a Copy For Your Records.

Section E. Medicare Coverage – *Complete this section if you, your dependent or your spouse is covered under Medicare.*

Health Insurance Social Security Act	**Health Insurance Social Security Act**
NAME OF BENEFICIARY _______________________	NAME OF BENEFICIARY __________________________
CLAIM NUMBER _____________________	CLAIM NUMBER ________________________
SEX ______	SEX ______
IS ENTITLED TO **EFFECTIVE DATE** HOSPITAL (PART A) __________________	**IS ENTITLED TO** **EFFECTIVE DATE** HOSPITAL (PART A) _________________
MEDICAL (PART B) __________________	MEDICAL (PART B) _________________
MEDICARE + CHOICE (HMO) ___________________	MEDICARE + CHOICE (HMO) __________________
This is *the information as it exists currently on your Medicare ID card.*	This is *the information as it exists currently on your Medicare ID card.*
Entitled To Medicare Due To (Check all that applies): ☐ Age 65 ☐ Disability ☐ ESRD – Provide 1st Dialysis Date _________ – Provide Kidney Transplant Date _________	**Entitled To Medicare Due To** (Check all that applies): ☐ Age 65 ☐ Disability ☐ ESRD – Provide 1st Dialysis Date _________ – Provide Kidney Transplant Date _________

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. "Aetna" is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies.

Please Retain a Copy For Your Records.