



# OTHER HEALTH INSURANCE QUESTIONNAIRE

Send completed form to: EmblemHealth HMO, PO Box 9091, COB Unit, Melville, NY 11747-9890  
EmblemHealth PPO, PO Box 2804, New York NY 10116-2804

## SECTION A - SUBSCRIBER INFORMATION

SUBSCRIBER NAME: LAST FIRST MI			INSURANCE ID #:		
SUBSCRIBER ADDRESS:			DATE OF BIRTH: ____/____/____	SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	MARITAL STATUS:
CITY:	STATE:	ZIP:	EMPLOYER NAME		
ARE YOU CURRENTLY EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO ARE YOU CURRENTLY RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO If retired, please give date of retirement: ____/____/____			EMPLOYER ADDRESS:  Number of persons working for your employer: _____		
<b>Are you covered under any other insurance plan?</b> <input type="checkbox"/> YES (Please complete section B, C and D) <input type="checkbox"/> NO (Please complete section B) (Including Medicare, Medicaid, Workers Compensation, No-Fault, TRICARE, COBRA, other group health plan, Black Lung, federal, state or local government plan)					

## SECTION B - SPOUSE INFORMATION

SPOUSE'S NAME: (Last, First, MI)		SPOUSE'S SOCIAL SECURITY NUMBER: ____/____/____		SPOUSE'S SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
SPOUSE'S DATE OF BIRTH (MM/DD/YY): ____/____/____		IS YOUR SPOUSE EMPLOYED? <input type="checkbox"/> YES <input type="checkbox"/> NO IS YOUR SPOUSE RETIRED? <input type="checkbox"/> YES <input type="checkbox"/> NO If retired, please give date of retirement: ____/____/____			
<b>Is your spouse covered under any other insurance plan?</b> <input type="checkbox"/> YES (Please complete section C) <input type="checkbox"/> NO (Including Medicare, Medicaid, Workers Compensation, No-Fault, TRICARE, COBRA, other group health plan, Black Lung, federal, state or local government plan)					

## SECTION C - OTHER INSURANCE COVERAGE

Please complete this section if you or any member of your family have any other health coverage

NAME OF PERSON WHO IS THE SUBSCRIBER OF OTHER COVERAGE		POLICY NUMBER:	
INSURANCE COMPANY NAME: EFFECTIVE DATE: ____/____/____		INSURANCE COMPANY PHONE NUMBER:	
CONTRACT TYPE: <input type="checkbox"/> INDIVIDUAL <input type="checkbox"/> FAMILY <input type="checkbox"/> PARENT/CHILD <input type="checkbox"/> SUBSCRIBER/SPOUSE If applicable, please attach a copy of any court order for dependent health coverage.  Check all that apply: <input type="checkbox"/> MEDICAL <input type="checkbox"/> HOSPITAL <input type="checkbox"/> DENTAL <input type="checkbox"/> PRESCRIPTION <input type="checkbox"/> NO FAULT <input type="checkbox"/> WORKERS COMPENSATION Date of Accident/Injury: ____/____/____		NAME AND ADDRESS OF PLAN PROVIDING THE OTHER COVERAGE:	

## SECTION D - MEDICARE COVERAGE

ARE YOU OR ANY OF YOUR FAMILY COVERED BY MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO		IF YES, WHAT IS THE REASON FOR MEDICARE ENTITLEMENT? <input type="checkbox"/> AGE <input type="checkbox"/> DISABILITY <input type="checkbox"/> END STAGE RENAL DISEASE Date of 1st Dialysis Treatment ____/____/____	
SUBSCRIBER'S INFORMATION MEDICARE NUMBER:		SPOUSE OR FAMILY MEMBER'S INFORMATION MEDICARE NUMBER:	
EFFECTIVE DATE PART A ____/____/____	EFFECTIVE DATE PART B ____/____/____	EFFECTIVE DATE PART A ____/____/____	EFFECTIVE DATE PART B ____/____/____

## SECTION E - CERTIFICATION

I certify that the information given is correct and that benefits are not available under any other Group Plan except as indicated where applicable in Section C and Section D of this form. Any person who knowingly and with intent to defraud any Insurance Company or any other person who files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a Civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

SIGNATURE:	DATE SIGNED:
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