EmblemHealth®

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: ☐ MALE ☐ FEMALE	MARITAL STATUS:
CITY:	STATE:	ZIP:	EMPLOYER NAME		
ARE YOU CURRENTLY EMPLOYED? ☐ YES ☐ NO ARE YOU CURRENTLY RETIRED? ☐ YES ☐ NO If retired, please give date of retirement: ____/_____/_____			EMPLOYER ADDRESS: Number of persons working for your employer: _____		

Are you covered under any other insurance plan? ☐ YES (Please complete section B, C and D) ☐ 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: ☐ MALE ☐ FEMALE
SPOUSE'S DATE OF BIRTH (MM/DD/YY): ____/_____/_____	IS YOUR SPOUSE EMPLOYED? ☐ YES ☐ NO IS YOUR SPOUSE RETIRED? ☐ YES ☐ NO If retired, please give date of retirement: ____/____/____	

Is your spouse covered under any other insurance plan? ☐ YES (Please complete section C) ☐ 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: ☐ INDIVIDUAL ☐ FAMILY ☐ PARENT/CHILD ☐ SUBSCRIBER/SPOUSE If applicable, please attach a copy of any court order for dependent health coverage. Check all that apply: ☐ MEDICAL ☐ HOSPITAL ☐ DENTAL ☐ PRESCRIPTION ☐ NO FAULT ☐ 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? ☐ YES ☐ NO	IF YES, WHAT IS THE REASON FOR MEDICARE ENTITLEMENT? ☐ AGE ☐ DISABILITY ☐ END STAGE RENAL DISEASE Date of 1st Dialysis Treatment _____/_____/_____

SUBSCRIBER'S INFORMATION		SPOUSE OR FAMILY MEMBER'S INFORMATION	
MEDICARE NUMBER:		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: