MUNICIPAL HEALTH BENEFIT PROGRAM
MULTIPLE COVERAGE INQUIRY

This completed form is REQUIRED at time of enrollment

Please complete this form and return it as soon as possible

MHBP Member/Employee Name	Member/Employee SSN or ID#	Name of Employer/Group	
Current Mailing Address	City	State	Zip Code

1. PLEASE ANSWER THIS QUESTION

Do you or any family member covered as your dependent by MHBP, have any other medical, dental or vision insurance coverage?

Yes ☐ If Yes, please move to Section 2

No ☐ If No, please sign and date the bottom of the next page

2.OTHER INSURANCE INFORMATION - ALL FIELDS REQUIRED (More space provided on page 2)

(If Other Insurance is Medicare, Please go to Section 3 of this form)

Name of Insurance Company		Insurance Company Phone Number ( )	
Insurance Company Address (Street or PO Box, City, State and Zip Code)		Employer that provides this coverage	
Name of Policyholder	Policy Holder Identification No.	Effective Date	Termination Date *

Type of Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Drug Card Services

Type of Policy ☐ Single ☐ Family ☐ Medicaid ☐ Retiree/Cobra Coverage

Persons Covered by Other Insurance

Name of person covered on above policy	Social Security Number	Date of Birth	Relationship

3. Medicare Information (PLEASE PROVIDE COPY OF MEDICARE CARD)

Name of Medicare Policyholder		Medicare Identification Number
Effective Date of Part A	Effective Date of Part B	Effective Date of Part D

Reason for Medicare Eligibility: ☐ **Age 65 or Older** ☐ **Disability *** ☐ **Renal Disease**

*** If you are eligible for Medicare due to a Disability please attach a copy of Social Security Disability Approval Letter.**

Name of Spouse or other dependent who has Medicare		Medicare Identification Number
Effective Date of Part A	Effective Date of Part B	Effective Date of Part D

Reason for Medicare Eligibility: ☐ **Age 65 or Older** ☐ **Disability *** ☐ **Renal Disease**

*** If you are eligible for Medicare due to a Disability please attach a copy of Social Security Disability Approval Letter.**

NOTE: ALL CLAIMS ON YOU & YOUR COVERED DEPENDENTS WILL BE HELD UNTIL THIS INFORMATION IS RECEIVED. FAILURE TO RESPOND TO MAY RESULT IN CLAIMS BEING DELAYED OR DENIED.

MHBP Use Only

4.IF YOU ARE DIVORCED AND/OR COVERING CHILDREN FROM A PREVIOUS RELATIONSHIP OR COVERING STEPCHILDREN

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No **A copy of court order must accompany this form.**

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No **A copy of court order must accompany this form.**

Name of Dependent	Who does the dependent reside with	Relationship to Member/Employee

Is there a Court or Child Support Order in place establishing financial responsibility for the dependent(s) health coverage:
☐ Yes ☐ No **A copy of court order must accompany this form.**

OTHER INSURANCE INFORMATION CONT'D.

Name of Insurance Company		Insurance Company Phone Number ( )	
Insurance Company Address (Street or PO Box, City, State and Zip Code)		Employer that provides this coverage	
Name of Policyholder	Policy Holder Identification No.	Effective Date	Termination Date *

*** If the other coverage has terminated please attach a copy of the termination letter**

Type of Coverage ☐ Medical ☐ Dental ☐ Vision ☐ Drug Card Services
Type of Policy ☐ Single ☐ Family ☐ Medicaid ☐ Retiree Coverage

Persons Covered by Other Insurance

Name of person covered on above policy	Social Security Number	Date of Birth	Relationship

NOTE: ANY CHANGES TO THIS INFORMATION MUST BE SUBMITTED TO MHBP USING THIS FORM. IF THE COVERAGE TERMINATES PLEASE ATTACH A CERTIFICATE OF COVERAGE SHOWING THE TERMINATION DATE.

Signature of Member/Employee Date

(rev 03/2022)