OTHER COVERAGE STATEMENT

ASEA Health Benefits Trust

Address: PO Box 5434, Spokane, WA 99205 • Phone: 866-553-8206 (toll-free); 509-328-0300
Fax: 509-323-7614 • Website: www.aseahealth.org

Use this form to provide information about other health insurance coverage for yourself and your dependents.

PLEASE PRINT CLEARLY

Date:

Employee name: SSN or Alternate ID:

Please complete the following questions and return this form, signed and dated to the above address as soon as possible.

Are you or any other family member covered by any other insurance plan? ❑ Yes ❑ No If yes, please complete the following:

Name of other insurance company:

Policyholder name:

Policy number: Effective date:

List family members covered by the other plan:

Type of coverage (check all that apply): ❑ Medical ❑ Dental ❑ Vision ❑ Prescription

If divorced or legally separated, does the decree specify which parent is responsible for providing health and/or dental coverage for the children? If yes, please, include a complete copy of the decree, custodial and/or financial order. ❑ Yes ❑ No

Name of parent with custody:

If your other insurance has terminated, please provide a copy of the Notice of Termination.

CERTIFICATION

I certify that the above is true, correct and complete.

Employee signature: Date:

Any person who knowingly and with intent to defraud or deceive any health plan, files a statement of claim containing any materially false, incomplete, or misleading information is guilty of a crime and may be liable for substantial civil penalties.