OTHER COVERAGE FORM

MERITAIN[SM] HEALTH

An Aetna Company

Meritain Health Welcomes You! We are asking for your help in getting information on other Medical insurance coverage currently in effect for you or your dependents. This information will expedite claims processing and enhance your level of service. ***If we do not receive this information, it may delay the processing and payment of your claims.***

Please print:

Employee Name: _____

Employee Identification Number: _____

Name of Company (your employer): _____

Policy number (if known): _____

Employee Signature & Date: _____

Do you or any of your dependents have other coverage in effect at this time?

Medical: ☐ Yes ☐ No

Medicare: ☐ Yes ☐ No

If your answer is No for all of the above, please return this form via fax, mail or email to: (763) 852-5079 or mail to:

Attn: Enrollment
Meritain Health
1405 Xenium Lane North Suite 140
Minneapolis, MN 55441

Fax number (763) 852-5079

Email: enroll@meritain.com

If you answered Yes to any of the above, please provide the information below and return as directed above.

MEDICAL

Name of insurance company: _____

Name of policyholder: _____

Effective date of coverage: _____

Please list **all** family members covered by this plan:

_____

MEDICARE

Name of policyholder: _____

Effective date of coverage: _____

Please list **all** family members covered by this plan:

_____