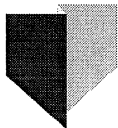


OTHER COVERAGE FORM



MERITAINSM
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: