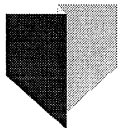


# OTHER COVERAGE FORM



**MERITAIN<sup>SM</sup>**  
**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](mailto: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: