

Other Health Insurance

If you, your spouse, or your eligible dependents also have other insurance plan(s), complete the questions below so we can coordinate health benefits with your other insurance carrier(s). It is important to complete this information as accurately as possible. By doing so, you will prevent unnecessary paperwork from being mailed to you after medical services have been provided.

On the date this change will take effect, will you or any family member(s) be covered by any other group medical insurance (not replacing this plan)? Yes No

If yes, please complete this information:

Name of person with other insurance/plan _____ Type of coverage: Single Family

Please list names of covered family members _____

Name of insurance co. _____ Phone No. _____

Address _____ City _____ State _____ Zip _____

Group No. _____ Certificate No. _____

Policy: Effective date _____ Termination date _____ Will you be terminating coverage? Yes No

Is this a group policy/plan offered through an employer? Yes No If no, what is it offered through? _____

Termination Of Coverage Attestation

Please complete this section if you checked the "Lost other qualifying coverage" box at the beginning of this form.

Have you or any of your dependents had coverage under any other health insurance within the past 30 days?

Yes No

If so, with what company and what kind of policy? Company _____

Kind of policy _____

What are your dates of coverage under the other policy (mm/dd/yy)? Start ____/____/____ End ____/____/____
(If you are still covered under this plan, leave "END" blank.)

Name of current insurance company: _____

Name of individuals covered: _____

Your identification and group number with current insurance company: _____

Reason for termination: _____

I hereby attest that my previous health insurance coverage was terminated on ____/____/____. I understand that inaccuracies in reporting this date could constitute fraud or misrepresentation and could result in rescission of my health insurance plan with Health Tradition and potential other legal consequences.

Signature _____ Date _____

Printed Name _____

Signature

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, clinic, medically related facility, insurance or reinsuring company, or third party administrator having medical information about myself or my minor children to disclose such information to Health Tradition Health Plan, its third-party administrator, other insurers/plans (including Centers for Medicare & Medicaid Services) and other healthcare providers as necessary for the provision or evaluation of services, the determination of claims or requests for services or benefits under my enrollment, or the administration of the plan. This authorization shall be valid for two and one-half years from the date shown below. I agree that a photographic copy of this authorization shall be valid as the original. I or my authorized representative can request and receive a copy of this authorization from the Plan at any time I am enrolled with this Plan. I or my authorized representative have the right to revoke this authorization in writing at any time.

Employee Signature Date Signed

Spouse Signature (if to be insured) Date Signed

Adult Dependent Signature Date Signed

Adult Dependent Signature Date Signed

ACKNOWLEDGEMENT: I understand that Health Tradition Health Plan reserves the right to accept or decline this application in whole or in part. I further understand that no contractual right is created by this application or advance premium payment and the same shall not be considered accepted unless or until the benefit plan is issued to me. If a benefit plan is issued, I understand and agree with all notices, including, but not limited to, premium billings and Explanation of Benefits required to be sent under the terms of the benefit plan will be sent to the Subscriber. I have read this application in its entirety and certify the information is accurate and complete. I understand and agree that any false statements or omissions may void any benefit plans issued based on this application. I further understand a person who submits an application or files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

I hereby apply for the group coverage and authorize deductions from my earnings for the amount required, if any, to cover any contribution for group coverage.

Employee Signature Date Signed

Spouse Signature (if to be insured) Date Signed

**Waiver
Section**

To be
completed
only if
refusing
coverage

Coverage is being waived for myself or my family for the following reason:

Covered under my spouse's group health plan Covered under an individual health insurance policy

Other _____

If waiving due to other coverage, please provide the name(s) of individual(s) waiving coverage:

If you are waiving/declining medical coverage for yourself and/or your dependents (including your spouse) because of other health coverage, you may in the future be able to enroll yourself and/or your dependents when other coverage ends, provided that you request enrollment within 30 days after other coverage ends.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and/or your dependents provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption.

If you waive/decline medical coverage for yourself and/or dependents for any other reason, you may not enroll outside of an open enrollment period, if any.

I proclaim that I was not pressured or forced by the employer named above, the writing agent, Health Tradition Health Plan, or Mayo Clinic Health Solutions into waiving the above noted coverage. I freely and voluntarily waive the above noted coverage.

Employee Signature

Date Signed

Spouse Signature

Date Signed