CHEMUNG COUNTY HEALTH INSURANCE DEPARTMENT
OTHER INSURANCE COVERAGE INFORMATION FORM
Required Form - Please Print Legibly

Subscriber Information:

Name:_____ SSN:_____ DOB:_____
Address:_____ Home Phone:_____ ☐ Male ☐ Female
_____ County Department**:**_____ Union:_____
or Participating Group:_____

Eligible Dependent Information:

NAME	RELATIONSHIP	SSN	DOB	
_____	_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	_____	☐ Male ☐ Female
_____	_____	_____	_____	☐ Male ☐ Female

Do you, your spouse/dependents have any other health insurance coverage? ☐ **Yes** ☐ **No**
(as of effective date)

If yes, complete each applicable coverage section and sign the form below.
If coordination of benefits for dependents should not be calculated by the birthday rule, please indicate which coverage is primary and reason (ie. court order):_____

If no, but you, your spouse or dependents previously had other coverage, please complete each applicable coverage section, indicate the date other coverage listed ended, complete each section and sign the form below.
Please note: You may need to provide proof of coverage end date.

Other Insurance Information:

Insured Name:_____ Employer:_____
DOB:_____ Relationship to covered family members:_____

COVERAGE TYPE	INSURANCE CARRIER	SUBSCRIBER ID#	EFFECTIVE DATE	ALL FAMILY MEMBERS COVERED?	COVERAGE END DATE
MEDICAL	_____	_____	_____	☐ Yes ☐ No*	_____
PRESCRIPTION	_____	_____	_____	☐ Yes ☐ No*	_____
VISION	_____	_____	_____	☐ Yes ☐ No*	_____
DENTAL	_____	_____	_____	☐ Yes ☐ No*	_____

**If not all family members covered by other insurance, please define who is covered under which plan(s)*:*

_____
_____
_____

I hereby certify that all information provided on this form is accurate and complete. I understand that it is my responsibility to notify the Chemung County Insurance Department with any changes to the information on this and all enrollment forms. If at any time any of my dependents or I become ineligible for health insurance under this plan, it is understood that failure to report this information within 30 days can result in having to reimburse the County for any costs incurred including premiums for coverage or claims paid.

_____
Subscriber's Signature *Date*

Revised 3/24/15