

EMPLOYEE: COMPLETE THE FOLLOWING. PLEASE PRINT.

Please list names of any **dependents who are Medicare-eligible and their Medicare number:**

NAME (FIRST AND LAST)	MEDICARE NUMBER
SPOUSE	
DEPENDENT	
DEPENDENT	

Additional health benefits information

Other coverage (that is not Group Health Cooperative or Group Health Options, Inc.) _____

Who is the subscriber under this plan? _____

What is their social security or policy number with this plan? _____ Attach any certificate of creditable coverage letters to this form.

Your contract may contain coverage exclusions for Pre-Existing Conditions (PEC). These exclusions could be fully or partially waived based on prior or current coverage. Review this section carefully and complete the information requested for both you and your dependents to assure proper processing of your claims.

NAME (FIRST AND LAST)	CURRENT OR PREVIOUS CARRIER (INCLUDE PHONE NUMBER)	COBRA	DATE COVERAGE BEGAN (MM/DD/YY)	DATE COVERAGE ENDED (MM/DD/YY)
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		
		<input type="checkbox"/> Yes <input type="checkbox"/> No		

(Signature of employee)

(Date signed)

Please retain a copy for your records.