Other Coverage Information

Employer or Plan Name LAKOTA LOCAL SCHOOL DISTRICT Employee Name

Employee Social Security _____ - _____ - _____ OR Unique ID Number

Do you or any of your dependents have other health coverage?

☐ No *If no, sign, date, and return to HR Dept.* ☐ Yes *If yes complete the following for each person that carries other coverage*

DEPENDENT #1 WITH COVERAGE (Specify last name if different from yours	GENDER (M or F)	SOCIAL SECURITY #	DATE OF BIRTH MM/DD/YYYY	TYPE OF COVERAGE (Check all that apply)
Name: Relationship:			/ /	☐ Medical ☐ Dental ☐ Vision ☐ Medicare HIC# _____ EFFECTIVE DATE: / /
Employer Name: Address: Phone Number			Insurance Co. / Group name: Address: Phone Number:	
DEPENDENT #2 WITH COVERAGE (Specify last name if different from yours	GENDER (M or F)	SOCIAL SECURITY #	DATE OF BIRTH MM/DD/YYYY	TYPE OF COVERAGE (Check all that apply)
Name: Relationship:			/ /	☐ Medical ☐ Dental ☐ Vision ☐ Medicare HIC# _____ EFFECTIVE DATE: / /
Employer Name: Address: Phone Number			Insurance Co. / Group name: Address: Phone Number:	
DEPENDENT #3 WITH COVERAGE (Specify last name if different from yours	GENDER (M or F)	SOCIAL SECURITY #	DATE OF BIRTH MM/DD/YYYY	TYPE OF COVERAGE (Check all that apply)
Name: Relationship:			/ /	☐ Medical ☐ Dental ☐ Vision ☐ Medicare HIC# _____ EFFECTIVE DATE: / /
Employer Name: Address: Phone Number			Insurance Co. / Group name: Address: Phone Number:	

Is the other coverage a result of a court or divorce decree? ☐ Yes ☐ No
If yes, please attach a copy of the decree outlining financial responsibility for insurance coverage (s)

Signature_____ Date: _____

FAX COMPLETED FORM TO EBMC 614-766-1007: ATTN. ELIGIBILITY DEPARTMENT