Other Coverage Information

Employer Name: Noble Local School District

Employee Name:

Secure ID # (on Healthcare Card):

Do you or your covered dependents have other medical coverage? ☐Yes ☐ No
Do you or your covered dependents have other dental coverage? ☐Yes ☐ No
Do you or your covered dependents have other vision coverage? ☐Yes ☐ No

(If the answer is **NO**, you can **STOP and go to the dependent name information below**)

If yes, provide:

Type of Coverage: ☐ Medical ☐ Dental ☐ Vision
Name(s) of Covered Person(s)

____

____

Effective Date ____________________

Employer Name____

Name of other insurance company or claims payer:

____
NAME ADDRESS

Are you or any enrolled dependents covered by Medicare as the result of disability?
☐ Yes ☐ No If yes: Medicare effective date __________________
Mo Day Yr

Name of person(s) covered by Medicare:

____

If other coverage is stipulated by a divorce decree or other court order, please submit a copy of the court documents outlining financial responsibility for health care expenses.

***If No,* Covered dependents Social Security Numbers (please attach additional sheet if more space is needed)**

Name	Relationship	Social Security #
____________________	________________	______________________
____________________	________________	______________________
____________________	________________	______________________
____________________	________________	______________________
____________________	________________	______________________
____________________	________________	______________________

Signature____ Date___________