2020-2021 HEALTH CARE ENROLLMENT FORM

In order to accurately process your claims, information regarding other health care coverage is needed. Please complete the information below (please print legibly) and then sign at the bottom of the form.

LAST NAME: _____**FIRST NAME:** _____**MI:** _____

LAST 4 DIGITS OF YOUR SOCIAL SECURITY NUMBER: _____ _____ _____ _____

YOUR ADDRESS: _____

Do you have any other insurance coverage for health, dental, vision or Medicare?

___ **YES I have coverage and am declining coverage** (complete form and sign.)

___ **NO I do not have coverage and am required to** (sign form and return to your Program Director.)

NAME(S) OF POLICYHOLDER & TYPE OF COVERAGE

HEALTH INSURANCE:

Health Insurance Provider: _____ Policy #: _____

Is the Policyholder your ___ Spouse ___ Parent ___ Other _____
(State Relationship)

Type of Coverage: ___ Group ___ Individual

MEDICARE:

Health Insurance Provider: _____ Policy #: _____

Is the Policyholder your ___ Spouse ___ Parent ___ Other _____
(State Relationship)

Type of Coverage: ___ Group ___ Individual

I attest the information provided on this form is accurate.

SIGNATURE: _____ **DATE:** _____

****REQUIRED TO BE COMPLETED BY ALL FT MEMBERS – EVEN IF DECLINING****