

Other Insurance Addendum

If you answered YES to having any other Health Insurance or Prescription Drug coverage, please complete and return this form with your application. If you answered NO, you do not need to complete or return this form.

Name	Medicare Number
Please specify the type of insurance:	
<input type="checkbox"/> Active Employer Group Insurance	<input type="checkbox"/> Retiree Coverage
<input type="checkbox"/> Veteran's Administration Coverage	<input type="checkbox"/> Direct Pay Policy
<input type="checkbox"/> Federal Black Lung Coverage	<input type="checkbox"/> Supplemental Coverage
<input type="checkbox"/> Workman's Compensation Coverage	
Please specify type of coverage:	
<input type="checkbox"/> Medical Only	<input type="checkbox"/> Medical with Prescription Drugs
<input type="checkbox"/> Dental or Vision Only	<input type="checkbox"/> Prescription Drug Only
Is this insurance provided by:	
<input type="checkbox"/> Your Employer	<input type="checkbox"/> Your Spouse's Employer
	<input type="checkbox"/> Individual Plan
Does your employer have:	
<input type="checkbox"/> 1-19 employees	<input type="checkbox"/> 20-99 employees
	<input type="checkbox"/> more than 100 employees
Does your spouse's employer have:	
<input type="checkbox"/> 1-19 employees	<input type="checkbox"/> 20-99 employees
	<input type="checkbox"/> more than 100 employees
Your employer's name: _____	Your insurance name: _____
Your insurance policy #: _____	Your insurance group #: _____
Spouse's employer's name: _____	Spouse's insurance name: _____
Spouse's insurance policy #: _____	Spouse's insurance group #: _____

Member's Signature*

Date

* Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that:
 1) this person is authorized to under State law to complete this form and 2) documentation of this authority is available upon request by the plan or Medicare.

If you are the authorized representative, you must provide the following information:

Name: _____ Address: _____
 Phone: _____ Relationship to Enrollee: _____

Highmark Inc., Highmark Health Insurance Company, and Keystone Health Plan West are health plans with a Medicare contract with the Federal government.