OTHER HEALTH INSURANCE (OHI) INFORMATION FORM

(This only needs to be completed *if* you have Spouse and/or Dependent Children covered under this plan.)

Other **H**ealth **I**nsurance (OHI) coverage is medical coverage through an employer-sponsored group plan and/or Medicare or Medicaid under which the member is covered either as an employee, retiree or dependent. Please fully complete the information below to identify whether or not you or any family member covered under this Employer's Plan has medical coverage through one of these types of plans.

If this form is not completed and returned, claims will be pended until this information is received.

Group Name:		**Group Number:**	
EMPLOYEE	LAST NAME:	FIRST NAME:	M.I.:
Phone number: (H) __________________, (W) ___________________ (C) ___________________		Social Security Number:	Date of Birth:

SPOUSE	LAST NAME:			FIRST NAME:		M.I.:	
Phone number: (H) __________________, (W) ___________________ (C) ___________________				Social Security Number:		Date of Birth:	
OHI:	___Yes ___ No (If Yes, fill out gray.)	If yes, please provide the following information:	OHI Policy Holder Name:			Policy Holder's Date of Birth:	
OHI Policy Holder relation to Employee:	__Self, ___Spouse, __ Parent, __Other (_____)	Type of Coverage:		___Active ___Medicare ___Retiree ___Medicaid ___COBRA		*OHI Effective Date (If Medicare, include Part A & B dates):	
If Medicare coverage, reason for coverage:		___ Over 65 ___ Disabled ___ End Stage Renal Disease ___ Other __________________					
OHI Policy Holder's Employer:		Group Number:			Policy ID Number:		
OHI Policy Holder's Address:							
OHI Carrier Name, Address & Phone Number:							

CHILD #___	LAST NAME:		FIRST NAME:		Date of Birth:
Relation to Employee: __Natural Child, __Step-Child, __Adopted Child, __Foster Child, __ Under Legal Guardianship					
**Child's Parents are __Separated, __Divorced or __Never Married			Who has physical custody?		
Mother's Name (if not listed above), Address & Phone No.:					
Father's Name (if not listed above), Address & Phone No.:					
Child's Address if different than Employee's: __ same as other address listed above; __ other=					
OHI: ___Yes ___ No If, Yes, same as Spouse above ___ Yes ___ No (If Yes, do not fill out gray)		OHI Policy Holder Name:			Policy Holder's Date of Birth:
OHI Policy Holder relation to Dependent:	__Self, __ Parent, __Spouse, __Other (___________)	Type of Coverage:	___Active ___Medicare ___Retiree ___Medicaid ___COBRA		*OHI Effective Date (If Medicare, include Part A & B dates):
If Medicare coverage, reason for coverage: ___ Disabled ___ End Stage Renal Disease ___ Other __________________					
OHI Policy Holder's Employer:		Group Number:	Policy ID Number:		OHI Carrier Name & Phone Number:
OHI Policy Holder's Address:					
OHI Carrier Name, Address & Phone Number:					

*Please attach a copy of the ID card for any other insurance plans.

** If "yes", please attach/send a copy of the following portions of the separation agreement/divorce decree: a) the first page which identifies the petitioner and respondent; b) any pages that reference custody and insurance; and c) the judge's signature page (usually the last page of the document). Note: Please be sure to include these same pages for any attachments (i.e., parenting plan, separation agreement, etc.) that is referenced in the decree.

Please return these OHI forms with your enrollment form to your HR/Benefits Office. Thereafter, please notify Med-Pay immediately if any of this information changes, (417) 886-6886 or (800) 777-9087.

____ ____________________

Employee Signature Date

(Continued on next page- OHI Form additional page for more Dependent Children)

OTHER HEALTH INSURANCE (OHI) INFORMATION FORM
(DEPENDENT CHILDREN)

Other **H**ealth **I**nsurance (OHI) coverage is medical coverage through an employer-sponsored group plan and/or Medicare or Medicaid under which the member is covered either as an employee, retiree or dependent. Please fully complete the information below to identify whether or not you or any family member covered under this Employer's Plan has medical coverage through one of these types of plans.
If this form is not completed and returned, claims will be pended until this information is received.

Group Name:			**Group Number:**
EMPLOYEE	LAST NAME:	FIRST NAME:	M.I.:
Phone number: (H) __________________, (W) ___________________ (C) ___________________		Social Security Number:	Date of Birth:

CHILD #___	LAST NAME:	FIRST NAME:	Date of Birth:
Relation to Employee: __Natural Child, __Step-Child, __Adopted Child, __Foster Child, __ Under Legal Guardianship			
**Child's Parents are __Separated, __Divorced or __Never Married		Who has physical custody?	
Mother's Name (if not listed above), Address & Phone No.:			
Father's Name (if not listed above), Address & Phone No.:			
Child's Address if different than Employee's: __ same as other address listed above; __ other=			
OHI: ___Yes ___ No If, Yes, same as Child above ___ Yes ___ No (If Yes, do not fill out gray)	OHI Policy Holder Name:		Policy Holder's Date of Birth:
OHI Policy Holder relation to Dependent: __Self, __ Parent, __Spouse, __Other (___________)	Type of Coverage:	___Active ___Medicare ___Retiree ___Medicaid ___COBRA	*OHI Effective Date (If Medicare, include Part A & B dates):
If Medicare coverage, reason for coverage: ___ Disabled ___ End Stage Renal Disease ___ Other __________________			
OHI Policy Holder's Employer:	Group Number:	Policy ID Number:	OHI Carrier Name & Phone Number:
OHI Policy Holder's Address:			
OHI Carrier Name, Address & Phone Number:			

CHILD #___	LAST NAME:	FIRST NAME:	Date of Birth:
Relation to Employee: __Natural Child, __Step-Child, __Adopted Child, __Foster Child, __ Under Legal Guardianship			
**Child's Parents are __Separated, __Divorced or __Never Married		Who has physical custody?	
Mother's Name (if not listed above), Address & Phone No.:			
Father's Name (if not listed above), Address & Phone No.:			
Child's Address if different than Employee's: __ same as other address listed above; __ other=			
OHI: ___Yes ___ No If, Yes, same as Child above ___ Yes ___ No (If Yes, do not fill out gray)	OHI Policy Holder Name:		Policy Holder's Date of Birth:
OHI Policy Holder relation to Dependent: __Self, __ Parent, __Spouse, __Other (___________)	Type of Coverage:	___Active ___Medicare ___Retiree ___Medicaid ___COBRA	*OHI Effective Date (If Medicare, include Part A & B dates):
If Medicare coverage, reason for coverage: ___ Disabled ___ End Stage Renal Disease ___ Other __________________			
OHI Policy Holder's Employer:	Group Number:	Policy ID Number:	OHI Carrier Name & Phone Number:
OHI Policy Holder's Address:			
OHI Carrier Name, Address & Phone Number:			

If necessary, make copies and attach additional pages of this OHI Form for more dependent children.

* Please attach a copy of the ID card for any other insurance plans.

****** If "yes", please attach/send a copy of the following portions of the separation agreement/divorce decree: a) the first page which identifies the petitioner and respondent; b) any pages that reference custody and insurance; and c) the judge's signature page (usually the last page of the document). Note: Please be sure to include these same pages for any attachments (i.e., parenting plan, separation agreement, etc.) that is referenced in the decree.

Please return these OHI forms with your enrollment form to your HR/Benefits Office. Thereafter, please notify Med-Pay immediately if any of this information changes, (417) 886-6886 or (800) 777-9087.

____ ________________________

Employee Signature Date