

## 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 Health Insurance (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.**

<b>Group Name:</b>			<b>Group Number:</b>		
<b>EMPLOYEE</b>	LAST NAME:	FIRST NAME:	M.I.:		
Phone number: (H) _____, (W) _____ (C) _____		Social Security Number:		Date of Birth:	

<b>SPOUSE</b>	LAST NAME:	FIRST NAME:	M.I.:		
Phone number: (H) _____, (W) _____ (C) _____		Social Security Number:		Date of Birth:	

OHI:	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please provide the following information:	OHI Policy Holder Name:	Policy Holder's Date of Birth:	
OHI Policy Holder relation to Employee:	<input type="checkbox"/> Self, <input type="checkbox"/> Spouse, <input type="checkbox"/> Parent, <input type="checkbox"/> Other (_____)	Type of Coverage:	<input type="checkbox"/> Active <input type="checkbox"/> Medicare <input type="checkbox"/> Retiree <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA	*OHI Effective Date (If Medicare, include Part A & B dates):	
If Medicare coverage, reason for coverage: <input type="checkbox"/> Over 65 <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Other _____					
OHI Policy Holder's Employer:		Group Number:		Policy ID Number:	
OHI Policy Holder's Address:					
OHI Carrier Name, Address & Phone Number:					

<b>CHILD #</b> _____	LAST NAME:	FIRST NAME:	Date of Birth:		
Relation to Employee: <input type="checkbox"/> Natural Child, <input type="checkbox"/> Step-Child, <input type="checkbox"/> Adopted Child, <input type="checkbox"/> Foster Child, <input type="checkbox"/> Under Legal Guardianship					
Child's Address if different than Employee's:					
OHI:	<input type="checkbox"/> Yes <input type="checkbox"/> No	OHI Policy Holder Name:		Policy Holder's Date of Birth:	
OHI Policy Holder relation to Dependent:	<input type="checkbox"/> Self, <input type="checkbox"/> Parent, <input type="checkbox"/> Spouse, <input type="checkbox"/> Other (_____)	Type of Coverage:	<input type="checkbox"/> Active <input type="checkbox"/> Medicare <input type="checkbox"/> Retiree <input type="checkbox"/> Medicaid <input type="checkbox"/> COBRA	*OHI Effective Date (If Medicare, include Part A & B dates):	
If Medicare coverage, reason for coverage: <input type="checkbox"/> Disabled <input type="checkbox"/> End Stage Renal Disease <input type="checkbox"/> Other _____					
OHI Policy Holder's Employer:		Group Number:	Policy ID Number:	OHI Carrier Name & Phone Number:	

**If the Child's Parents are <input type="checkbox"/> Separated, <input type="checkbox"/> Divorced or <input type="checkbox"/> Never Married			Who has physical custody?		
OHI Policy Holder's Address:					
OHI Carrier Name, Address & Phone Number:					
Mother's Name, Address & Phone No.:					
Father's Name, Address & Phone No.:					

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

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 page 3- OHI Form- Dependent Children)

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

Other Health Insurance (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.**

<b>Group Name:</b>			<b>Group Number:</b>		
<b>EMPLOYEE</b>	LAST NAME:	FIRST NAME:	M.I.:		
Phone number: (H) _____, (W) _____ (C) _____		Social Security Number:		Date of Birth:	

<b>CHILD #</b> ____	LAST NAME:	FIRST NAME:	Date of Birth:
---------------------	------------	-------------	----------------

Relation to Employee:  Natural Child,  Step-Child,  Adopted Child,  Foster Child,  Under Legal Guardianship

Child's Address if different than Employee's:

OHI: <input type="checkbox"/> Yes <input type="checkbox"/> No	OHI Policy Holder Name:	Policy Holder's Date of Birth:
---	-------------------------	--------------------------------

OHI Policy Holder relation to Dependent: <input type="checkbox"/> Self, <input type="checkbox"/> Parent, <input type="checkbox"/> Spouse, <input type="checkbox"/> Other (_____)	Type of Coverage:	<input type="checkbox"/> Active <input type="checkbox"/> Medicare <input type="checkbox"/> Retiree <input type="checkbox"/> Medicaid <input type="checkbox"/> 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:
-------------------------------	---------------	-------------------	----------------------------------

\*\*If the Child's Parents are  Separated,  Divorced or  Never Married Who has physical custody?

OHI Policy Holder's Address:

OHI Carrier Name, Address & Phone Number:

Mother's Name, Address & Phone No.:

Father's Name, Address & Phone No.:

<b>CHILD #</b> ____	LAST NAME:	FIRST NAME:	Date of Birth:
---------------------	------------	-------------	----------------

Relation to Employee:  Natural Child,  Step-Child,  Adopted Child,  Foster Child,  Under Legal Guardianship

Child's Address if different than Employee's:

OHI: <input type="checkbox"/> Yes <input type="checkbox"/> No	OHI Policy Holder Name:	Policy Holder's Date of Birth:
---	-------------------------	--------------------------------

OHI Policy Holder relation to Dependent: <input type="checkbox"/> Self, <input type="checkbox"/> Parent, <input type="checkbox"/> Spouse, <input type="checkbox"/> Other (_____)	Type of Coverage:	<input type="checkbox"/> Active <input type="checkbox"/> Medicare <input type="checkbox"/> Retiree <input type="checkbox"/> Medicaid <input type="checkbox"/> 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:
-------------------------------	---------------	-------------------	----------------------------------

\*\*If the Child's Parents are  Separated,  Divorced or  Never Married Who has physical custody?

OHI Policy Holder's Address:

OHI Carrier Name, Address & Phone Number:

Mother's Name, Address & Phone No.:

Father's Name, Address & Phone No.:

***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