Harbor Health

Enrollee's Other Health Plan Coverage

Instructions

Provide the coverage information for each family member covered under your health plan.

You'll need to submit to the address listed on page 2 of this form.

Section 1: Health plan information

Relationship	Name	Date of Birth (DOB)	Covered by another plan?
Self (Primary subscriber)			☐ Yes ☐ No
Spouse			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No
Dependent			☐ Yes ☐ No

- If no one is covered by another plan, go to **Section 4** to sign and submit the form.
- If anyone has another plan, complete **Section 2**. Also complete **Section 3** if there's Medicare coverage.
- If there is more than one additional plan, provide the information in a separate copy.

Section 2: Other health plan information (Including Medicaid/CHIP)

Primary subscriber name _____ Primary subscriber DOB _____

Member ID / policy number (Include letters) _____ Group number _____

Health plan name _____ Health plan address _____

City _____ State _____ ZIP _____

Health plan phone number _____ Coverage start date _____ Coverage end date _____

Employer name _____ Subscriber is: ☐ Active ☐ Retired ☐ on COBRA

Plan is: ☐ Group ☐ Individual ☐ Supplemental ☐ Tricare

List each person covered by this plan:

Spouse _____ Dependent _____

Dependent _____ Dependent _____

Dependent _____ Dependent _____

A. If the other plan covers a child, provide:

Mother's name _____ DOB _____ Father's name _____ DOB _____

B. If parents are separated, divorced, or not married, list:

Child resides with _____ Relationship _____

Individual with custody _____ Relationship _____

C. Is there a court order establishing responsibility for health care coverage? '

☐ No ☐ Yes

If yes, provide the following: Responsible party _____ Relationship _____

If multiple children have coverage under another plan — and the information above is different, provide in a separate copy.

Section 3: Medicare coverage information

Medicare subscriber name _____ Medicare ID number _____

- ☐ Part A – Effective date _____
- ☐ Part B – Effective date _____
- Entitlement reason:
  - ☐ Age
  - ☐ Disability
  - ☐ End stage renal disease
    - If due to end stage renal disease, provide the first date of dialysis _____
    - ☐ Home dialysis ☐ Facility or dialysis center
    - Date of kidney transplant, if applicable _____

Section 4: Signature

_____ _____

Name of person completing the form | Relationship to primary subscriber

_____ _____

Signature | Date

Return completed form to:
Attn: Harbor Health Enrollment Team
Harbor Health Insurance Company
PO Box 211262
Eagan, MN 55121