



Other Health Insurance Verification Form

The information below is correct to the best of my knowledge. I hereby authorize any other carrier to give to Aetna information about any coverage they provide in relation to myself and/or other family members.

Aetna subscriber signature (or parent/guardian signature)

Date

Section A. Subscriber Information — To be completed by subscriber.

Name (First, Middle Initial, Last)		ID number
Street Address, City, State, Zip Code		
Employer's group name <input type="checkbox"/>		Employer's telephone number
State of Alaska (AlaskaCare)		
Type of plan <input type="checkbox"/> HMO <input type="checkbox"/> Open Choice <input type="checkbox"/> Managed Choice <input type="checkbox"/> Other _____		Policy/group number 866219
Aetna subscriber ID number (<i>as shown on your ID card</i>)	Are you employed by another employer/company? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes and you have coverage under another health plan, please, complete Section D, or E for Medicare.	
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retire - date retired _____ <input type="checkbox"/> Receiving COBRA benefits <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Other _____		

Section B. Spouse/Qualified Same Sex Partner Information — To be completed by subscriber.

Name (First, Middle Initial, Last)		ID number
Employer's Name		Employer's telephone number
Employer's Street Address, City, State, Zip Code		
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retire - date retired _____ <input type="checkbox"/> Receiving COBRA benefits <input type="checkbox"/> Long-Term Disability <input type="checkbox"/> Other _____		
Does your spouse/qualified same sex partner have other coverage? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes , complete Section D, or E for Medicare.		

Section C. Dependent Information — Complete each box for each dependent covered under your Aetna plan.

Name (First, Middle Initial, Last)	Date of Birth (MM/DD/YYYY)	Relationship to the subscriber Above C=Child; S=Stepchild; O=Other (specify)	Address/telephone (if different from the subscriber above)	Covered under another group coverage Y=yes; N=no
1.				
2.				
3.				
4.				
5.				
6.				

If **Yes** is noted for **Covered Under Another Group Coverage** column on any of the dependent child(ren)/stepchild(ren) listed above, complete **Section D** and the following:

- Who are the legal parents of the child(ren)? _____
- Date of birth For each parent (MM/DD/YYYY) **father:** _____ **mother:** _____

If parents are separated or divorced, complete the following:

- Is there a court order establishing which parent is financially responsible for the dependent child(ren)'s medical, dental, or other health care expenses? Yes No If **Yes**, specify who _____
- Who has custody of the dependent child(ren)? _____
- Who do the child(ren) reside with? _____
- How many months of the year? _____

Member number (required)

Section D. Other Insurance Carrier Name and Telephone Number — Complete this section if you or your dependents are covered under another insurance plan.

Name of other insurance carrier (1)		Other insurance carrier telephone number	
Name of subscriber of this policy	ID number (as shown on your ID card)	Effective date (MM/DD/YYYY)	
Employer's name		Employer's telephone number	Length of employment year(s) _____ month(s) _____
Type of coverage <input type="checkbox"/> Family <input type="checkbox"/> Individual	Type of benefit provided (check all that applies) <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Student <input type="checkbox"/> Pharmacy		
Who is covered under this group coverage (enter individual's name):			
1. _____	2. _____	3. _____	
4. _____	5. _____	6. _____	
Name of other insurance carrier (2)		Other insurance carrier telephone number	
Name of subscriber of this policy	ID number (as shown on your ID card)	Effective date (MM/DD/YYYY)	
Employer's name		Employer's telephone number	Length of employment year(s) _____ month(s) _____
Type of coverage <input type="checkbox"/> Family <input type="checkbox"/> Individual	Type of benefit provided (check all that applies) <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Student <input type="checkbox"/> Pharmacy		
Who is covered under this group coverage (enter individual's name):			
1. _____	2. _____	3. _____	
4. _____	5. _____	6. _____	

Section E. Medicare Coverage — Complete this section if you, your dependent or your spouse is covered under Medicare.

HEALTH INSURANCE SOCIAL SECURITY ACT		HEALTH INSURANCE SOCIAL SECURITY ACT	
Name of beneficiary	_____	Name of beneficiary	_____
Claim number	_____	Claim number	_____
Sex	_____	Sex	_____
Is entitled to	Effective date	Is entitled to	Effective date
Hospital (Part A)	_____	Hospital (Part A)	_____
Medical (Part B)	_____	Medical (Part B)	_____
Medicare Advantage (HMO)	_____	Medicare Advantage (HMO)	_____
<i>This is the information as it exists currently on your Medicare ID card.</i>		<i>This is the information as it exists currently on your Medicare ID card.</i>	
Entitled to Medicare due to (check all that applies):		Entitled to Medicare due to (check all that applies):	
<input type="checkbox"/> Age 65	<input type="checkbox"/> Disability	<input type="checkbox"/> Age 65	<input type="checkbox"/> Disability
<input type="checkbox"/> ESRD	– Provide 1st dialysis date _____	<input type="checkbox"/> ESRD	– Provide 1st dialysis date _____
	– Provide kidney transplant date _____		– Provide kidney transplant date _____

You can return this form to us by fax or mail: **Aetna**
PO Box 14079
Lexington, KY 40512-4079
Fax: 1-859-455-8650

Warning: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to claim was provided by the applicant. **“Aetna” is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company and its affiliates (Aetna).**