# Aetna™ Other Coverage Form

The information below is correct to the best of my knowledge. I hereby authorize any other carrier to provide to Aetna information relating to any coverage provided by that carrier 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) | | Social Security Number |
|---|---|---|
| Street Address, City, State, Zip Code | | |
| Employer's Group Name | Employer's Telephone Number | Employment Status<br>☐ Active ☐ Retire - **Date Retired** _____ |
| Type of Plan<br>☐ HMO ☐ Open Choice ☐ Managed Choice ☐ Other _____ | | Policy/Group Number |
| Aetna Subscriber ID Number ***(as shown on your ID card)*** | Are you employed by another employer/company?<br>☐ No ☐ Yes If "Yes" and you have coverage under another health plan, please, complete **Section F**. | |

**Section B. Spouse/Domestic Partner Information** — *To be completed by subscriber.*

| Name (First, Middle Initial, Last) | Social Security Number |
|---|---|
| Employer's Name | Employment Status<br>☐ Active ☐ Retire - **Date Retired** _____ |
| Employer's Address/Telephone Number | Does your Spouse/Domestic Partner have other coverage?<br>☐ No<br>☐ Yes If "Yes", complete **Section C**. |

**Section C. Other Insurance Carrier/Company Information** — *To be completed by subscriber.*

| Name of Other Insurance Carrier (1) | | ID Number *(as shown on your ID card)* | Group/Policy Number | Effective Date (MM/DD/YYYY) |
|---|---|---|---|---|
| Type of Coverage<br>☐ Family ☐ Individual | Telephone Number | Type of Benefit Provided (check all that applies)<br>☐ Medical ☐ Dental ☐ Vision ☐ Student ☐ Pharmacy | | |
| Name of Other Insurance Carrier (2) | | ID Number *(as shown on your ID card)* | Group/Policy Number | Effective Date (MM/DD/YYYY) |
| Type of Coverage<br>☐ Family ☐ Individual | Telephone Number | Type of Benefit Provided (check all that applies)<br>☐ Medical ☐ Dental ☐ Vision ☐ Student ☐ Pharmacy | | |

**Section D. 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. | | | | |

If "Yes" is noted for **Covered Under Another Group Coverage** column on any of the dependent child(ren/stepchild(ren) listed above, complete **Section F** 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? _____

**Complete All Sections That Apply.**

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

| **Subscriber is:** | **Health Insurance** | **Spouse/** | **Health Insurance** |
|---|---|---|---|
| ☐ **Employed**<br>☐ **Not Employed**<br>☐ **Retired**<br>**Retired Date:** _____ | **SOCIAL SECURITY ACT**<br>NAME OF BENEFICARY _____<br>CLAIM NUMBER _____ SEX _____<br>**IS ENTITLED TO** **EFFECTIVE DATE**<br>HOSPITAL (PART A) _____<br>MEDICAL PART B) _____<br>*This is the information as it exists currently on your Medicare ID card.* | **Dependent is:**<br>☐ **Employed**<br>☐ **Not Employed**<br>☐ **Retired**<br>**Retired Date:** _____ | **SOCIAL SECURITY ACT**<br>NAME OF BENEFICARY _____<br>CLAIM NUMBER _____ SEX _____<br>**IS ENTITLED TO** **EFFECTIVE DATE**<br>HOSPITAL (PART A) _____<br>MEDICAL PART B) _____<br>*This is the information as it exists currently on your Medicare ID card.* |
| **Entitled to Medicare Due To** (check all that applies): | ☐ **Age 65** ☐ **Disability**<br>☐ **ESRD – Provide 1st Dialysis Date** _____ | **Entitled to Medicare Due To** (check all that applies): | ☐ **Age 65** ☐ **Disability**<br>☐ **ESRD – Provide 1st Dialysis Date** _____ |

**Section F. Other Commercial Coverage** — *Complete this section if you or your dependents are covered under another group coverage.*

| Name of Other Insurance Carrier (1) | | ID Number *(as shown on your ID card)* | Group/Policy Number | Effective Date (MM/DD/YYYY) |
|---|---|---|---|---|
| Type of Coverage<br>☐ Family ☐ Individual | Telephone Number | Type of Benefit Provided (check all that applies)<br>☐ Medical ☐ Dental ☐ Vision ☐ Student ☐ Pharmacy | | |
| Name of Other Insurance Carrier (2) | | ID Number *(as shown on your ID card)* | Group/Policy Number | Effective Date (MM/DD/YYYY) |
| Type of Coverage<br>☐ Family ☐ Individual | Telephone Number | Type of Benefit Provided (check all that applies)<br>☐ Medical ☐ Dental ☐ Vision ☐ Student ☐ Pharmacy | | |

**Section G. Other Automobile Coverage*** — *Only complete when benefits have been paid or are being paid by your automobile coverage for medical treatment you are currently receiving as a result of an accident.*

***Note:** Aetna only coordinates benefits with automobile coverage as permitted by law.

| Name of Person(s) Involved In Accident | | Date of Accident (MM/DD/YYYY) |
|---|---|---|
| Auto Insurance Company Name | Auto Insurance Policy Number | Auto Insurance Company Telephone Number |
| Auto Insurance Company Address | | |
| Briefly describe the injuries for each family member: | | |

**Section H. Other Worker's Compensation Coverage**** — *Only complete if benefits have been exhausted or if benefits are denied by your worker's compensation carrier.*

****Note:** Exhaustion of your worker's compensation benefits or denial from your compensation carrier does not guarantee benefits. Refer to your plan of benefits for coverage under your Aetna plan.

| Name of Person(s) Involved In Accident | | Date of Accident (MM/DD/YYYY) |
|---|---|---|
| Worker's Compensation Name | Worker's Compensation Number | Worker's Compensation Telephone Number |
| Worker's Compensation Address | | |
| Briefly describe the injuries for each family member: | | |

**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.