



Annual Insurance Update

RE: ALL EMPLOYEES AND THEIR DEPENDENTS

To properly evaluate medical insurance claims for this current plan year on you, your spouse and your dependents, the following information is required and **will be requested annually**:

Have you, your covered spouse, or any of your covered dependents had in the past, or currently have, any other health insurance coverage?

Yes No If Yes, please provide the following information:

Name of other Policy Holder _____
Policy _____ Holder's _____ date _____ of _____ birth _____

Name of Company the other Policy Holder is/was employed with _____

Name and Phone Number of the other Insurance Carrier _____

Effective date of other coverage _____ End date of other coverage _____

List all who are/were covered under the other insurance:

_____ Relationship to the other policyholder _____
_____ Relationship to the other policyholder _____
_____ Relationship to the other policyholder _____
_____ Relationship to the other policyholder _____
_____ Relationship to the other policyholder _____

Are any of your dependents/spouse disabled? Yes No If yes, who? _____
For what condition? _____

The statements made above are true and accurate to the best of my knowledge. I understand that federal laws provide for criminal penalties for submitting knowingly or making false, fictitious or fraudulent statement or claim in any manner. Because personal information is requested from you, we are required by HIPAA to notify you of the following: This information is requested under the authority of Chapter 55, Title 10, United States Code, Section 1076A. The information is requested to update enrollment records to process claims. Routinely, this information will be used to determine eligibility for benefits and to review and process claims. **Please return this letter to Insight Benefit Administrators, fax 616-588-5341, or email ra_tpa@insightba.net.**

Signature of Insured _____ Date _____

Print name of Insured _____

Name of Employer _____

