Insight
Benefit Administrators

In order to properly evaluate claims for the patient and your spouse/dependents, the following information is required and will be requested annually.

Name of other Policy Holder

First Name Last Name

Do you, your spouse or any of your dependents currently have or in the past year have had other insurance coverage besides the coverage you have administered through Insight Benefit Administrators?

Policy Holder's date of birth

Month Day Year

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

Name and Phone Number of the other Insurance Carrier

Check other coverage that applies:

- [ ] Medical
- [ ] Dental
- [ ] Vision

Effective date of other coverage

Day Year

End date of other coverage

Month Day Year

List all who are/were covered under the other insurance and their relationship to you.

Are any of your dependents/spouse disabled?

If yes, 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 in order to process claims. Routinely, this information will be used to determine eligibility for benefits and to review and process claims.

Name of Employee

First Name Last Name