Associate Other Insurance Form

EMPLOYER Grande Cheese Company
GROUP NUMBER 76-411544

Your response is required. We are collecting the following information to verify if you or your covered family members have any other medical coverage. Please fill in or circle the answers below, even if you or your family members have no other medical insurance. **Failure to provide the information below will delay the processing of your medical claims.**

Other Insurance Information

Associate Name (Print) ______________________________ Plan Year ______________

1. Is your spouse/domestic partner offered medical insurance through his/her employer?
   a. Yes
   b. No
   c. N/A- Spouse is not employed

2. If you answered "Yes" to question #1, is your spouse/domestic partner enrolled in their employer medical insurance?
   a. Yes
   b. No

3. If you answered "No" to question #2, why did your spouse/domestic partner not elect their employers medical insurance?
   a. Cost of premiums/deductible
   b. Plan coverage was insufficient
   c. Medical providers didn't meet your needs
   d. Other (Explain) ____

4. Do you or your covered family members have any other medical insurance? (Employer Coverage, Medicare, Badger Care, Affordable Care Insurance, Medicaid, COBRA insurance plan, etc.)
   a. Yes
   b. No

5. If you answered "Yes" to question #2 or #4, please complete the following information?

Name(s) of member(s) with other insurance coverage: ____

Plan holder/Insurance Company Name: ____

Medical Plan Number: __________________________ Medicare HIC Number: ____________________

Coverage Type: ____Single ____Single +1 ____Family

6. If any of your covered family members have court-ordered medical coverage, please return this form with the medical coverage section of your Court Decree.

Please complete this form and return to the Grande HR Benefits department. Failure to complete and return this form will delay payment of your medical claims. I hereby certify all information given by me is accurate and true.

________________________________ ______________ ____________________________

Associate Signature Date UMR Member ID#

Date received in HR Benefits Department ____