A. Member/Dependent Information

<table>
<thead>
<tr>
<th>Member/Dependent Legal Last Name</th>
<th>Member/Dependent Legal First Name</th>
<th>Mem/Dep MI</th>
<th>Mem/Dep ID Number</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

Please provide the following information:

Does the above referenced individual have other insurance? □ Yes □ No

If No, please sign and date this form and return this form to our office at the address or fax number listed above.

**NOTE:** If the above referenced member/dependent previously had other insurance coverage that has recently terminated, a Certificate of Credible Coverage (COCC) from the other insurance carrier is required in order for claims to be paid correctly. Please include a copy of the COCC with this form as proof of termination from the other insurance carrier.

If Yes, please answer the following:

Does this person carry coverage on dependents? □ Yes □ No

If No, please complete Section B below for yourself, then sign and date this form and return it to our office at the address/fax listed above, or

If Yes, list names of all dependents and complete Section B below.

B. Other Insurance Information

<table>
<thead>
<tr>
<th>Other Insurance Company Name</th>
<th>Policy Holder’s Name</th>
<th>Relationship to Dependent(s)</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Policy Holder’s Date of Birth

Dependents covered under plan (if applicable):

1 _______________ 2 _______________ 3 _______________ 4 _______________

If more than 4 dependents covered under this policy holder, please attach list to this page.

Dependent Effective Date – **REQUIRED FOR PROMPT CLAIMS PAYMENT**

Coverage Includes: □ Medical □ Dental □ Vision □ Prescription

C. Signature

I hereby declare under penalty of perjury that the information on this form is correct and complete to the best of my knowledge. Upon request by the Plan, I agree to obtain and furnish a copy of any divorce decree, support order, or other relevant documents. I understand that if any incorrect or misleading information on this form results in a loss to the Plan, the Plan is entitled to recover the amount of such a loss from me or by withholding from my future benefits.

Member/Dependent Signature (REQUIRED) ____________ Date ____________