Coeur Plan Services, LLC

P.O. Box 592869, San Antonio, Texas 78259
Phone: (210) 981-1220 / (844) 582-6387
Email: Claims@CoeurPlanServices.com / Fax: (210) 981-1210

RE: Other Health Insurance Inquiry
Benefit Year: _____

Dear **Participant**:

To be able to process claims accurately and timely, we need to know if your dependents have other health insurance coverage, including Medicare or Medicaid. Please provide the following information and return the completed form to Coeur: Claims@CoeurPlanServices.com

1. Do your dependent(s) have any Health Insurance coverage other than your coverage with Coeur?
   ☐ No (If no, please sign & date) ☐ Yes (if yes, please proceed to question 2)

2. Please complete the following information about the other Health Plan coverage:
   Name of Carrier & Phone #: _____
   Effective Dates of Coverage: _____

3. Please complete the following information concerning the above coverage. Include all members covered under the above policy and their dates of birth: (If additional space is needed, please attached a separate piece of paper.)

   Dependent's Name: _____ DOB: _____
   Dependent's Name: _____ DOB: _____
   Dependent's Name: _____ DOB: _____
   Dependent's Name: _____ DOB: _____

I certify that the information provided is accurate for the Benefit Year noted above.

_____ _____
Employee Signature Date

_____ _____
Employee's Name Member ID

_____
Employer Name

In good health!

Coeur Claims Department