St Luke's™ Health Plan

Multiple Coverage Inquiry Form

REQUIRED INFORMATION: OTHER COVERAGE

Do you or any family member have any other health insurance coverage or has any such coverage (Medical, Vision, Dental) existed during the last twelve months?

☐ **YES**–If yes, please complete Sections 1, 2, 3, 4 & 5 of this form, print, sign, date and mail it to us.

☐ **NO**–If no, please print, sign and date Section 5 of this form, and mail it to us.

1. Other Coverage Information (Subscriber/Employee)		
Required		
Insurance Company/Health Plan/Employer-Sponsored Medical Plan:	Phone Number:	
Address Line 1:		
Address Line 2:		
City:	State:	Zip Code:
Name of Policyholder/Member [you, your spouse, domestic partner, parent(s)]:	Relationship to You:	Date of Birth:
Policyholder/Member ID#:	Number of employees at the other Policyholder's/Member's Company: ☐ 1-19 ☐ 20-99 ☐ 100+	
Employer Name:	Employer Group ID# (if applicable):	
Type of Enrollee/Type of Group (check all that apply): ☐ Active ☐ Retiree ☐ COBRA ☐ Group ☐ Individual		
Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy	Coverage Effective Date:	Coverage Termination Date:

2. Medicare Information (Subscriber/Employee)	
Required if Medicare Enrollee	
Medicare Part A Effective Date:	Medicare Part B Effective Date (if enrolled):
Medicare Entitlement: ☐ Age ☐ Disability ☐ End Stage Renal Disease (ESRD)	
If Medicare entitlement is due to ESRD, the following fields must also be completed.	
First date of dialysis:	
Where was dialysis started? ☐ Facility ☐ Home	
Has a kidney transplant been performed? ☐ Yes ☐ No	If yes, date of transplant:

3. Family Members' Other Coverage (Other Dependents)			
If your family member has coverage under this plan, please provide all additional coverage, including Medicare, your family members have had during the last 12 months.			
First Name:	Last Name:		Date of Birth:
Other Coverage: ☐ Yes ☐ No	Other Coverage Member ID:	Effective Date:	Term Date:
Other Coverage Insurance or Plan Name:	Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		
Type of Enrollee/Type of Group (check all that apply): ☐ Active ☐ Retiree ☐ COBRA ☐ Group ☐ Individual			
First Name:	Last Name:		Date of Birth:
Other Coverage: ☐ Yes ☐ No	Other Coverage Member ID:	Effective Date:	Term Date:
Other Coverage Insurance or Plan Name:	Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		
Type of Enrollee/Type of Group (check all that apply): ☐ Active ☐ Retiree ☐ COBRA ☐ Group ☐ Individual			
First Name:	Last Name:		Date of Birth:
Other Coverage: ☐ Yes ☐ No	Other Coverage Member ID:	Effective Date:	Term Date:
Other Coverage Insurance or Plan Name:	Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		
Type of Enrollee/Type of Group (check all that apply): ☐ Active ☐ Retiree ☐ COBRA ☐ Group ☐ Individual			
First Name:	Last Name:		Date of Birth:
Other Coverage: ☐ Yes ☐ No	Other Coverage Member ID:	Effective Date:	Term Date:
Other Coverage Insurance or Plan Name:	Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		
Type of Enrollee/Type of Group (check all that apply): ☐ Active ☐ Retiree ☐ COBRA ☐ Group ☐ Individual			

3. Family Members' Other Coverage (CONTINUED)			
First Name:	Last Name:		Date of Birth:
Other Coverage: ☐ Yes ☐ No	Other Coverage Member ID:	Effective Date:	Term Date:
Other Coverage Insurance or Plan Name:	Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		
Type of Enrollee/Type of Group (check all that apply): ☐ Active ☐ Retiree ☐ COBRA ☐ Group ☐ Individual			
First Name:	Last Name:		Date of Birth:
Other Coverage: ☐ Yes ☐ No	Other Coverage Member ID:	Effective Date:	Term Date:
Other Coverage Insurance or Plan Name:	Type of Coverage (check all that apply): ☐ Medical ☐ Dental ☐ Vision ☐ Pharmacy		
Type of Enrollee/Type of Group (check all that apply): ☐ Active ☐ Retiree ☐ COBRA ☐ Group ☐ Individual			

4A. Support/Custody Information (Complete for all your covered dependents)
Are dependent(s)' parents divorced or legally separated? ☐ Yes ☐ No
(If NO, you DO NOT need to complete the rest of this section. If YES, complete Section 4B.)

4B. Support/Custody Information (CONTINUED)				
If divorced or legally separated, is either parent required by a divorce decree or court order to provide health coverage? If so, please attach divorce decree.				
☐ Mother is required	☐ Father is required	☐ Both are required	☐ Neither are required	
Parent with Custody:				
First Name:	MI:	Last Name:	Date of Birth:	Insurance Company/Health Plan:
Step-Parent with Custody:				
First Name:	MI:	Last Name:	Date of Birth:	Insurance Company/Health Plan:
Parent without Custody:				
First Name:	MI:	Last Name:	Date of Birth:	Insurance Company/Health Plan:
Step-Parent without Custody:				
First Name:	MI:	Last Name:	Date of Birth:	Insurance Company/Health Plan:

5. REQUIRED: SUBSCRIBER MUST PRINT AND SIGN	
I certify that the above information is correct and understand that I am obliged to provide this information to St. Luke's Health Plan in accordance with Plan provisions. Document must be completed, signed, and mailed for claims to be considered. Failure to provide complete and accurate information may result in a delay in the payment of benefits. Mail to: St. Luke's Health Plan, P.O. Box 91010, Seattle, WA 98111-9110. You can also call the number on your member ID card or go to **stlukeshealthplan.org** to print and fill out this form.	
Signature:	Date:

PRIVACY NOTICE: St. Luke's Health Plan is committed to the responsible management, use, and protection of non-public personal information. It is necessary for us to collect a certain amount and type of personal information in order to provide you with the services you purchase and administer your health coverage. Except when conducting necessary and normal business and services such as administering your double coverage and coordination of benefits, or as otherwise permitted or required by law, St. Luke's Health Plan will not disclose any personal health information without first obtaining a valid authorization.