Alliance Coal Health Care Program
Other Health Plan Questionnaire

Employee Name: ______________________________________ Employee #: ________________________

When you or your family members have health insurance through more than one source, benefits must be coordinated to avoid overpayment. This questionnaire asks about other health insurance coverage that your children may have. We depend on your help to process your claims correctly and appreciate your prompt and accurate reply.

Employee Name:____ **Employee ID:**________________
(Please print)

1. **Do you currently have any children who are covered by another Health Plan besides the Alliance Coal Health Plan?**

   Yes ☐
   No ☐

2. **If Yes, please provide each child's full name and date of birth.**
   If No, please skip questions 3-6 and sign and date the form below.

   Name: ___________________________________ Date of Birth: ______________

   Name: ___________________________________ Date of Birth: ______________

   Name: ___________________________________ Date of Birth: ______________

   Name: ___________________________________ Date of Birth: ______________

If there are multiple Health Plans, please attach a separate sheet of paper with the below information provided.

3. **What is the name and phone number of the other insurance plan? Check all that apply.**

   Plan Name: ____

   Phone Number: _______________________________________

   Medical ☐
   Dental ☐
   Vision ☐

4. **What is the Member ID #, Group ID # and effective date for the other health plan?**

   Member ID: ____

   Group ID: ____

   Effective Date: ______________________________________

5. **Please provide the name of the policy holder, their date of birth and relationship to the dependent child(ren):**

   Name: ____________________________ **Date of Birth:** __________________________

   Relationship: ____

6. **Is coverage for a child of a parent that is divorced or legally separated?**

   If yes, please submit a copy of the most recent divorce decree.

   Yes ☐
   No ☐

Employee Signature: ____ **Date:** ______________

Please return the completed questionnaire to your local HR representative

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