4. OTHER COVERAGE INFORMATION

Applicant (Fill in Yes or No)

Do you currently have or have you had health insurance in the past 11 months?

○ YES Coverage Start Date (MMDDYY): ☐☐☐☐☐☐ Coverage End Date (MMDDYY): ☐☐☐☐☐☐

Has the coverage been continuous during the past 11 months? ○ Yes ○ No

Will your current group insurance remain in effect afte you enroll in this Empire plan? ○ Yes ○ No

Name of Other Insurance Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ Your ID Number from Other Carrier ☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Provided by Employer? ○ Yes ○ No Employment Status: ○ Active ○ Retired

Contract Type: ○ Employee/Spouse ○ Individual ○ Parent/Child(ren) ○ Family

Coverage Type: ○ Hospital/Medical ○ Hospital Only ○ Medical Only ○ Other: ☐☐☐☐☐☐☐☐☐☐

○ NO

Spouse / Dependent(s) (Fill in Yes or No)

Does your spouse / dependent(s) currently have or have they had health insurance in the past 11 months?

○ YES Coverage Start Date (MMDDYY): ☐☐☐☐☐☐ Coverage End Date (MMDDYY): ☐☐☐☐☐☐

Has the coverage been continuous during the past 11 months? ○ Yes ○ No

Will their current group insurance remain in effect after you enroll in this Empire plan? ○ Yes ○ No

○ My spouse has or has had the same coverage as I. Note: You do not need to fill out the rest of the spousal other coverage questions.

○ My dependents have or have had the same coverage as I. Note: You do not need to fill out the rest of the dependent other coverage questions.

Spouse

Name of Spouse's Other Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Start Date (MMDDYY) ☐☐☐☐☐☐ Coverage End Date (MMDDYY) ☐☐☐☐☐☐ Coverage Provided by Employer? ○ Yes ○ No Employment Status: ○ Active ○ Retired

Contract Type: ○ Employee/Spouse ○ Individual ○ Parent/Child(ren) ○ Family

Coverage Type: ○ Hospital/Medical ○ Hospital Only ○ Medical Only ○ Other: ☐☐☐☐☐☐☐☐☐☐

Dependent 1

Name of Dependent's Other Insurance Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Start Date (MMDDYY) ☐☐☐☐☐☐ Coverage End Date (MMDDYY) ☐☐☐☐☐☐ Coverage Provided by Employer? ○ Yes ○ No Employment Status: ○ Active ○ Retired

Contract Type: ○ Employee/Spouse ○ Individual ○ Parent/Child(ren) ○ Family

Coverage Type: ○ Hospital/Medical ○ Hospital Only ○ Medical Only ○ Other: ☐☐☐☐☐☐☐☐☐☐

Dependent 2

Name of Dependent's Other Insurance Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Start Date (MMDDYY) ☐☐☐☐☐☐ Coverage End Date (MMDDYY) ☐☐☐☐☐☐ Coverage Provided by Employer? ○ Yes ○ No Employment Status: ○ Active ○ Retired

Contract Type: ○ Employee/Spouse ○ Individual ○ Parent/Child(ren) ○ Family

Coverage Type: ○ Hospital/Medical ○ Hospital Only ○ Medical Only ○ Other: ☐☐☐☐☐☐☐☐☐☐

Dependent 3

Name of Dependent's Other Insurance Carrier ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ID Number ☐☐☐☐☐☐☐☐☐☐☐☐

Coverage Start Date (MMDDYY) ☐☐☐☐☐☐ Coverage End Date (MMDDYY) ☐☐☐☐☐☐ Coverage Provided by Employer? ○ Yes ○ No Employment Status: ○ Active ○ Retired

Contract Type: ○ Employee/Spouse ○ Individual ○ Parent/Child(ren) ○ Family

Coverage Type: ○ Hospital/Medical ○ Hospital Only ○ Medical Only ○ Other: ☐☐☐☐☐☐☐☐☐☐

○ NO