OTHER COVERAGE STATEMENT

ASSURED BENEFITS ADMINISTRATORS

Please complete the form below in order to avoid delays in processing your claims and mail it to:

Assured Benefits Administrators
P.O. Box 211517
Eagan, MN 55121-2717

If you and your dependents are enrolled in another medical, vision and/or dental plan, please indicate below any other coverage. This would include coverage through an employer, a spouse's plan, a parent's plan, Medicaid, Medicare, etc.

If you have any questions, contact us at 1-800-247-7114. Our customer service representatives are available Monday through Friday from 8 a.m. to 6 p.m. Central Standard Time.

EMPLOYEE NAME _____ EMPLOYER _____

SSN _____ PHONE _____ EMAIL _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU OR YOUR DEPENDENTS CURRENTLY HAVE ANY OTHER HEALTH INSURANCE COVERAGE? ☐ YES ☐ NO

*If **YES**, provide the information requested below:*

NAME OF COVERED PERSON _____

OTHER INSURANCE CARRIER _____ ELIGIBILITY DATES _____

NAME OF COVERED PERSON _____

OTHER INSURANCE CARRIER _____ ELIGIBILITY DATES _____

NAME OF COVERED PERSON _____

OTHER INSURANCE CARRIER _____ ELIGIBILITY DATES _____

NAME OF COVERED PERSON _____

OTHER INSURANCE CARRIER _____ ELIGIBILITY DATES _____

SIGNATURE _____ PRINT NAME _____

DATE _____