Plan Participant Name: ________________________________

Enrollee Number: ____________________

Dear CEBT Plan Participant:

It is time for our annual update of Other Insurance and Student Status information for you and your family members covered under the CEBT plan. Please complete both pages of this form and return it to us according to the instructions on the reverse side of the form.

OTHER INSURANCE

Do you or any covered family members have medical or dental coverage other than your CEBT coverage?

☐ **YES (Continue)** ☐ **NO (Please sign below and go to Student Status Verification Section)**

If Yes, please provide information about the other **medical** coverage.

Insurance Company Name ___________________________________ Policy/Group Number __________

Telephone Number (_____) _____ - _______ Effective Date of Coverage ___/___/___

Please provide information about the person who carries the other medical coverage.

Name ____ Date of Birth ___/___/___

Social Security or ID Number _____________________ Relationship to __________________________

Employer Name (if the other coverage is provided by an Employer plan) __________________________

If the above coverage is Medicare, please indicate the type of coverage:

☐ Part A (Inpatient Hospital) Effective ___/___/___ ☐ Part B (Outpatient/Medical) Effective ___/___/___

Names and effective dates of coverage of each dependent (if any) covered by the plan described above.

Full Name	Effective Date of Medical Coverage
______________________________________	___/___/___
______________________________________	___/___/___
______________________________________	___/___/___

If Yes, please provide information about the other **dental** coverage.

Insurance Company Name ___________________________________ Policy/Group Number __________

Telephone Number (_____) _____ - _______ Effective Date of Coverage ___/___/___

Please provide information about the person who carries the other medical coverage.

Name ____ Date of Birth ___/___/___

Social Security or ID Number _____________________ Relationship to __________________________

Employer Name (if the other coverage is provided by an Employer plan) __________________________

Names and effective dates of coverage of each dependent (if any) covered by the plan described above.

Full Name	Effective Date of Dental Coverage
______________________________________	___/___/___
______________________________________	___/___/___
______________________________________	___/___/___

I certify that the above information is true and complete.

Signature of Plan Participant ____ **Date** __________

Telephone Number (if additional information is needed) (_____) _____ - _______

Please proceed to the Student Status Verification Section