UnitedHealthcare Insurance Company of New York
P.O. Box 1600 Kingston NY 12402

Re: **Empire Plan**
Policy Number: 30500
Enrollee:
Identification Number:
Patient:

We recently received information indicating that you or someone in your family may have other insurance coverage.

For our records, please supply the following information:

OTHER INSURED'S ADDITIONAL INFORMATION

1. Do you or any of your enrolled dependents have health insurance with any other plan (including HMO's or Medicare) other than your Empire Plan coverage under Identification Number ? (Please circle:) YES or NO .

2. Name of the person with this 'other' insurance : ______________________

3. Are they.. (please circle) **a.** Actively employed **b.** Retired (if retired, date of retirement ______________.)
c. Medicare Disability (if Medicare Disabled, effective date of disability______________)
d. Other (please specify ______________________.)

4. Other insured's relationship to the enrollee: (please circle:)
a. Self b. Spouse c. Domestic Partner d. Child e. Grandchild f. Other _______

5. Their birthdate: ______________

6. Their Address (if different): ______________________

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7. Other Insured's Employer name: ______________________

8. Other Insured' s Employer Address: ______________________

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OTHER INSURANCE CARRIER INFORMATION (for the person listed in number 2 on first page)

9. Other Insurer (Insurance Company) Name: ______________________________

10. Other Insurer Address: ______________________________

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11. Other Insurer Telephone Number: ______________________________

12. Effective date of this coverage : ______________________________

13. Coverage End Date (if applicable): ______________________________

14. Coverage Type: (circle one) Individual or Family

15. ID Number for this Other Insurance Coverage: ______________________________

16. Group Number for this Other Insurance Coverage: ______________________________

17. Signature : ______________________________

If you have any questions or concerns, please contact one of our United Healthcare customer care professionals, toll free, at 1-877-7NYSHIP (1-877-769-7447) or write to us at the address above.