COORDINATION OF BENEFITS INFORMATION

	nd on your ID card)				Par	ticipant Con	tract ID
lave you, your spouse o	or your dependents	been covered by o	other gr	oup health inst	ıranı	ce or Medic	are in the past year?
☐ NO – Please skip the res		n the bottom of this		•			m, sign the bottom of
orm, and return to MCTW	/F.		this	form, and return	to M	CTWF.	
SECTION 2 OTHER O	GROUP HEALTH IN:	SURANCE INFOR	RMATIO	ON			
Please provide the follow D card. If more than one			-				= =
nformation. Cardholder Name				Relationship to	you		Date of Birth
Other Group Health Insurance Name		Phone Number			Policy Numb		r
Type of Medical Plan:	☐ Medicare / Medigap ☐ Medicaid ☐ COBRA Policy	☐Group Health ☐Individual Policy ☐Retiree Policy	Effectiv	e Date of Covera	ige	Termination	Date (attach carrier lette
Гуре of coverage: check all that apply)	☐ Medical ☐ Dental	☐ Vision ☐ Prescription Drugs		Employer			
Who is covered by this of				applicable.			
Name (first and last	Relationship to You				<u>Date of Birth</u>		
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B. SECTION 3 SPECIAL Fill out this section only indicated in the section of the section or contact in the section of the s	SITUATIONS if your children have o ourt order.	other group health					
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