



US FAMILY HEALTH PLAN

OTHER HEALTH INSURANCE INFORMATION FORM

Use this form to report any other health insurance you have. This is a DoD requirement of the US Family Health Plan at Johns Hopkins. (Other health insurance such as BlueCross BlueShield or other health maintenance organizations (HMOs).)

Subscriber Information				
Last Name		First Name	Middle Initial	Social Security No.
Street or P.O. Box		Apt. No.	City	State Zip Code
Policy #1				
Person(s) Covered				
Employer name		Insurance Company		
Insurance Company Address		City	State	Zip Code
()		/	/	/
Phone Number		Effective Date	Termination Date	
		3/01	<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Couple	
Policy #	Group Plan #		Policy Coverage	
Policy #2				
Person(s) Covered				
Employer name		Insurance Company		
Insurance Company Address		City	State	Zip Code
()		/	/	/
Phone Number		Effective Date	Termination Date	
			<input type="checkbox"/> Individual <input type="checkbox"/> Family <input type="checkbox"/> Couple	
Policy #	Group Plan #		Policy Coverage	
Medicare Information				
DoD requires that you provide Medicare identification numbers for all family members age 65 and older.				
		Part A		Part B
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name	ID#			
		<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name	ID#			

Return this form along with your US Family Health Plan at Johns Hopkins enrollment application.