PEQUOTPLUS
HEALTH BENEFIT SERVICES

Pequot Plus Health Benefit Services
Benefit Administrators
P.O. Box 3620
Mashantucket, CT 06338-3620

Questions? Please contact Customer Service at (860) 396-6489 Questions? Please contact Customer or (888) 779-6872	**Cell Phone: _____** **Home Phone: _____** **Email:**

PRINT NAME: _____
ID #: _____

FORM TO BE COMPLETED BY THE EMPLOYEE

Employee Information:

Do you have healthcare or dental benefits through any other employee insurance plan, through any other group health plan including Medicare, State or Retirement Program? ____ Yes ____No

If yes, please complete the following.

_____ COBRA Effective date _____
_____ Retiree Program Effective date _____
_____ State Medicaid Program Effective date _____
_____ Medicare Part A Effective date _____
_____ Medicare Part B Effective date _____
_____ Other: _____ Effective date _____

Medical	Dental	Vision

Spouse Information (if applicable):

Does your spouse work? _____ Yes _____ No Employer: _____
If yes, does your spouse have healthcare or dental benefits through their employer? _____ Yes _____ No
Does your spouse have healthcare or dental benefits through any other group health plan including Medicare, State or Retirement programs? _____ Yes _____ No

If yes, please complete the following:

_____ COBRA Effective date_____
_____ Retiree Program Effective date_____
_____ State Medicaid Program Effective date_____
_____ Medicare Part A Effective date_____
_____ Medicare Part B Effective date_____
_____ Other:_____ Effective date _____

Medical	Dental	Vision

Dependent Information (if applicable):

Do any of your children have other insurance? ___ Yes ___ No
Is other insurance a state Medicaid program? ___Yes ___ No If yes, complete Sections A & B.
Is there a court order/divorce decree to determine health care coverage/custody responsibility? ____Yes ____No
If yes, attach copy of sections that apply to health care responsibility or custody and complete Sections A and B below.

SECTION A-OTHER HEALTH INSURANCE INFORMATION

Name of person responsible for child's health care coverage? _____
What is their date of birth? _____
Please list below all insurance policies and which family members are covered under each policy. Please include policies held by non-custodial or step parents if the policy covers your child:

Policy Name **Medical/Dental/Vision** **Effective Date**

_____

SECTION B-CHILD CUSTODY INFORMATION

Child's name (first and last) **Who has custody?**

_____

_____

With whom does the child reside? _____

*****IMPORTANT*** Please also provide a copy of the insurance card(s) both front and back.**

Signature: _____ Date:_____

***Please be advised that payment of claims will not be released until the requested information is received. Further, failure to provide this information will result in the denial of your claims rendering you responsible for payment of these charges.**

Please complete, sign where indicated and mail your reply to the address listed above or fax to (860) 396-6157. If you have any questions, please call our Customer Service number at 888-779-6872. Please notify this department of any future changes in your coverage. Thank you for your cooperation.

➡ **FORMS CAN BE DROPPED OFF AT THE CUSTOMER SERVICE OFFICE AT EMPLOYEE ENTRANCE** ⬅

FOR OFFICE USE ONLY:
Date: _____
Time: _____
CSR: _____